

Lehigh County Adult Blended Case Management (BCM) Criteria Form

Name: _____

Today's Date: _____

Serious and persistent mental illness which interferes with the person's capacity to function over a prolonged period of time in important aspects of daily life, i.e. self-direction, employment, education, self-care, recreation and interpersonal relationships.

THE PERSON MUST MEET TWO OF THE THREE FOLLOWING CRITERIA TO BE REFERRED FOR AND ADMITTED FOR BCM SERVICES.

Check which of the following BCM admission Criteria the client meets (can be more than one):

- Criteria #1 – DIAGNOSIS
DSM IV Diagnosis of Schizophrenia or Chronic Mood Disorder (295 & 296)

- Criteria #2 – TREATMENT HISTORY
 - ____ Admission to a state mental hospital totaling 60 days within the past two years, or
 - ____ Two admissions to community inpatient psychiatric units totaling 20 or more days within the past two years, or
 - ____ Five or more face-to-face contacts with emergency services within the past two years, or
 - ____ Three or more years of continued attendance in a community MH service, or
 - ____ History of sporadic course of treatment evidenced by at least three missed appointments within the past six months, inability to or unwillingness to maintain medication regimen or involuntary commitment to MH outpatient treatment

- Criteria #3 – Global Assessment of Functions Scale
 - ____ 40 and below, or
 - ____ 60 or below if person is thirty-five years of age or younger and/or history of aggressive or violent behaviors (explain)

Using the criteria you checked off above as your guide; provide justification for why you are requesting BCM for this client. (For example – if the client meets criteria #2 because the client had 3 or more acute inpatient psych treatments in the past 12 months, please list the dates of these acute inpatient treatments, etc.).

**Lehigh County Mental Health
Blended Case Management Referral Form**

Name: _____ Date of Referral: _____

Date of Birth: _____ Sex: _____ SS #: _____

Address: _____ Phone #: _____

_____ Phone #: _____

Primary Language: _____ Relationship Status: _____ (S, M, W, D, Paramour)

Current Living Arrangement: _____

Community Connections: _____

Emergency Contact/Guardian's Name (if applicable): _____

Current MH Treatment Provider and Phone #: _____

Axis I:	_____	Referral must include:
Axis II:	_____	- psychiatric or diagnostic evaluation
Axis III:	_____	- treatment notes
Axis IV:	_____	- current medication list
Axis V:	_____	Send medical information as needed.

History of: (please circle all that apply)

Sexual Abuse Suicide Assault/Aggressive Behavior Fire Setting

Treatment History (including D&A): _____

Decompensation Pattern: _____

Insurance: _____ Income & Source: _____

Other Agency Involvement (Please list all that apply. Attach extra sheets as necessary.):

Name / Contact Information: _____

Name / Contact Information: _____

Reason for Referral for BCM: _____

Referring Staff: _____ Phone: _____

Referring Agency: _____