S.C.C.S.
MENTAL HEALTH SKILLS BUILDING
2002 Wakefield Avenue, Petersburg, Virginia 23805
Phone: (804) 733-1180
Fax: (804) 733-1181
www.2ndchancesyouthservices.com

Mental Health Skills Building Referral and Prescreening

Client Information (please print)

Name_____ Birth Date: _____ (m/dd/yyyy)

Contact number_____ Gender: M/F

Medicaid#:_____ Social Security#:_____

Address: _____

PCP Name/Number: _____

Serviceable Problems: (circle)

Functioning Skills	**Social Functioning**	**Cognitive Functioning**
Money management	maintain close relationships	learning new skills
Attending medical appointments	understanding social rules of conduct	completing tasks
Monitoring health	involved in social/recreational/religious activities	prioritizing activities
Medication compliance		read/write

Sleep Patterns

Difficulty falling asleep

Difficulty staying asleep

Difficulty staying awake
Nightmares

Eligibility Criteria

Please check Yes or No to indicate if the following criteria is met by individual seeking services

1. The client has one of the following as a primary Axis I DSM diagnosis:
   - ☐ YES
   - ☐ NO

   (a) Schizophrenia or other psychotic disorder as set out in the DSM OR
   (b) Major Depressive Disorder-Recurrent: Bipolar I; or Bipolar II OR
   (c) Any other Axis I mental health disorder that a physician has documented specific to the identified individuals within the past year to include the following:
      i. that is a serious mental illness
      ii. results in severe and recurrent disability
      iii. produces functional limitations in the individual's major life activities which are
      iv. documented in the individual's medical record
      the individual requires individualized training in order to achieve or maintain

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independent living in the community

2. The client shall require training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management.
   - ▫ Yes
   - ▫ No
3. Prior history of any of the following: psychiatric hospitalization; residential crisis stabilization; Intensive Community Treatment (ICT) or Program of Assertive Community (PACT) services; placement in a psychiatric residential treatment facility (RTC Level C), or Temporary Detention Order (TDO) evaluation as a result of decompensation related to serious mental illness
   - ▫ Yes
   - ▫ No
4. A prescription for anti-psychotic, mood stabilizing, or anti-depressant medications within the past 12 months prior to the assessment date,
   - ▫ Yes
   - ▫ No

Screening recommendation and disposition plan:

_____Based upon the above information and information obtained, applicant is appropriate for the program and will be admitted.

_____Based upon the above information and information obtained, applicant is NOT appropriate for the program and will be recommended for more appropriate services to meet his/her needs. Recommendations are: _____

Professional Authorization (person completing referral form)

Name: _____ Phone#:_____ Date: _____