FRONTIER BEHAVIORAL HEALTH
509.838.4651 107 S Division, Spokane WA 99202 www.fbhwa.org

PACT (Program for Assertive Community Treatment) Referral Form

PACT is an intensive, community and team-based approach with 75% of services provided outside of the office. PACT can assist with the coordination of basic needs, medication management, learning about and managing symptoms, improving skills for getting through the day, finding and keeping housing, getting help with drug or alcohol problems, and getting a job or going back to school for individuals with a diagnosis on the schizophrenia spectrum or bipolar I disorder.

REFERRAL DATE: _____ **REFERRED BY:**_____ **PHONE/EXT:** _____

AGENCY/PROGRAM/HOSPITAL: _____

INDIVIDUAL REFERRED:_____**DOB:** _____

PREFFERED NAME: _____ **FBH ID # (if applicable):** _____

ADDRESS:_____**PHONE:** _____

Gender and preferred pronouns: _____

Interpreter Needed: ☐ Yes ☐ No Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Type of Insurance: ☐ Public ☐ Private ☐ None Insurance Provider: _____

Client Consent

Is the individual aware of the referral and agreeable to learn more about PACT services? ☐ **Yes /** ☐ **No/** ☐ **Unsure**

Mental health diagnosis:

Areas of functional impairment (*Please select all that apply)*:

☐ Consistent inability to perform practical daily tasks needed to function in the community, such as maintaining personal hygiene, meeting nutritional needs, recognizing and avoiding common dangers or hazards to self or personal property.
☐ Consistent inability to be employed or to carry out homemaker roles.
☐ Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).
☐ Inability to meet medical or health needs, such as inconsistency in medication adherence.

FRONTIER BEHAVIORAL HEALTH
509.838.4651 107 S Division, Spokane WA 99202 www.fbhwa.org

Reason for referral (*Please select all that apply)*:

☐ High use of acute psychiatric hospitalization or crisis services.
☐ Persistent or recurrent severe major symptoms (e.g., affective, psychotic, suicidal)
☐ Coexisting substance-use disorder of significant duration (e.g., greater than 6 months)
☐ High risk or a recent history of being involved in the criminal justice system.
☐ In substandard housing, homeless, or at imminent risk of becoming homeless.
☐ Living in an inpatient bed or in a supervised community residence but clinically assessed to be able to live more independently if intensive services are provided.
☐ Inability to participate in traditional office-based services.

Personality disorders: Yes ☐ / No ☐
If yes, please describe:

Substance use or diagnosis: Yes ☐ / No ☐
If yes, please describe:

History of risk: including risk to self *(Suicidal ideation or attempts.),* **risk to others, grave disability. Include dates, circumstances, etc.** *(if applicable):*

History of violence: threats, violence, damage or destruction of property, etc. Include dates, circumstances, etc. *(if applicable):*

History of hosiptalizations *(including admission/discharge dates):*

TBI/Developmental disability: Yes ☐ / No ☐
If yes, please describe impact on client's functioning and ability to participate in services.

Housing Status *(Independent, group home, homeless, etc.):*

Other Information:

Please email this referral to pactreferral@fbhwa.org or submit via fax (509) 458-2410. If this referral is from psychiatric hospital or E&T, please attach a copy of the History and Physical (H&P), discharge summary and admission document with referral form. A release of information assists with clearer coordination of referral outcome.