

MIHS ACT Referral

Email to: bwilliams@magellanhealth.com & sghani@magellanhealth.com

To be completed by MIHS Team Member

Date of Referral:

Recipient's Name:

Date of Birth:

Address upon admission:

Able to return to address: Yes

No

Unknown

MIHS Social Worker:

Phone:

Pager:

MIHS Psychiatrist:

Pager:

Unit Number:

Diagnosis: I

II

III

IV

V

Reasons for Hospitalization:

To be completed by ACT Manager

Date:

Supportive Team Clinic:

CC:

Phone:

Notes:

ACT Team Clinic:

CC:

Phone:

To be completed by assigned ACT Team

Date interview completed:

Recommendation: Yes

Date of Transfer:

No

Justification:

Engagement

Plan:

Final Disposition: