Program of Assertive Community Treatment (PACT) Referral Form

Please download this form before filling it out.
Please fax to 617.855.4264, Attn: PACT Referral Coordinator

Form Submission Options

1. Recommended: Mass General Brigham HIPAA-Compliant Adobe Sign Portal

Click on the following link to submit your referral electronically. Please note that this submission method requires you to complete the referral in one sitting, so you may wish to review the form and collect information in advance.

Click here: Adobe Sign Portal

2. Fax

Download this document, which is a fillable PDF that you can type into and save. Complete and print pages 2-6. Fax to us, along with any supporting clinical notes/documentation, at 617.855.4264.

3. Postal Mail

Download this document, which is a fillable PDF that you can type into and save. Complete and print
pages 2-5. Mail, along with supporting clinical documents, via postal mail to:

McLean Hospital
Program of Assertive Community Treatment (PACT), ATTN: Referrals
115 Mill Street
Belmont, MA 02478

Note: Note: Form submission via fax or postal mail may result in a delay in response.
With any questions, please call us at

Program of Assertive Community Treatment (PACT) Referral Form

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Date: _____

Demographics:

Client Name: _____ **Client Phone Number:** _____
Client Email:_____ **DOB:** _____ **Age:** ____ **Sex:** ____
Preferred Pronouns: _____ **Marital Status:** _____
Client Preferred Method of Contact (phone/email/text): _____
Address (include name if it is an organization): _____
_____
Commute time between McLean and where they reside (from Google Maps):_____
Lives with:_____
How long has person resided there?: _____
Primary Family/Emergency Contact Name:_____
Primary Family/Emergency Contact Phone Number: _____
Primary Family/Emergency Contact Email:_____
Guardian Name and Phone Number (If applicable):_____
Does the client drive/have access to a vehicle? _____

Referral Information

Name of person completing this form: _____ **Phone number:**_____

Email: _____ **Relationship to client:** _____

If applicable, indicate clinic/institution: _____

Reason for referral at this time (Select all that apply):

☐ **No mental health care**

☐ **Has services, needs higher level of mental health support**

☐ **Has multiple psychiatric admissions in the past 6 months**

☐ **Unsuccessful in other levels of care**

☐ **Other:** _____

Is person interested in PACT services? ☐ **Yes** ☐ **No**

If no, why? _____

Is the family/support system interested in PACT services? ☐ **Yes** ☐ **No**

If no, why? _____

Current Clinical Information

Current Clinical Presentation (predominant symptoms):

_____

_____

_____

_____

Is person currently experiencing psychosis? ☐ **Yes** ☐ **No**

Current Diagnosis (can list multiple):

_____ _____

_____ _____

_____ _____

_____ _____

Current Medications (please include name, dose):

_____ _____

_____ _____

_____ _____

_____ _____

Does person take these as prescribed? ☐ **Yes** ☐ **No**

If no, what are the barriers? _____

Current Medical Issues:

_____ _____

_____ _____

_____ _____

_____ _____

Current Substance Use:

Substance	Frequency of Use

Is the person currently engaged in any treatment? ☐ **Yes** ☐ **No**

If no, what are the barriers to engagement? _____

_____

_____

If yes, what services are they currently engaged in? (please select all that apply)

	Provider Name	Organization (Location)	Phone/Fax
☐ Psychopharm			
☐ Therapy			
☐ DMH			
☐ VNA			
☐ Day Structure			
☐ Substance Abuse			
☐ Residential			
☐ Other: _____			

Does this person currently have any of the following? (Please select all that apply. If yes, please provide more detail):

☐ **Suicidal ideation:** _____

☐ **Homicidal ideation:** _____

☐ **Access to weapons:** _____

☐ **Guns in their home:** _____

☐ **Aggression/violence:** _____

Historical Clinical Information

Prior levels of care engaged in (please select all that apply):

☐ **Psychiatric inpatient**
☐ **VNA**
☐ **DMH (please indicate which services):** _____
☐ **Residential/group home (if known, please indicate the name):** _____
☐ **Continuing care (state hospital)**

Number of prior (lifetime) psychiatric inpatient admissions: _____

Most recent psychiatric inpatient admission (date and name of facility): _____

Has this person ever had any of the following (Please select all that apply. If yes, please provide more detail with date if known):

☐ **Psychosis:** _____

☐ **Suicidal ideation:** _____

☐ **Suicide attempts:** _____

☐ **Homicidal ideation:** _____

☐ **Access to weapons:** _____

☐ **Guns in their home:** _____

☐ **Aggression/violence:** _____

Has this person ever been arrested, charged, or convicted of anything? ☐ **Yes** ☐ **No**

If yes, please provide more detail and dates if known: _____

_____

_____

Please provide name of probation officer if applicable: _____

History of Substance Use:

Substance	Last Date of Use (If known)

History of trauma (please indicate type, person's age when it occurred and pertinent details if known): _____

_____

_____

Psychosocial Functioning

Family involvement and family dynamic: _____

_____

_____

_____

_____

Is there any domestic violence that you are aware of? ☐ **Yes** ☐ **No**

If yes, please provide more detail: _____

_____

_____

Other social supports or community involvement: _____

_____

_____

Is there a family history of mental illness? ☐ **Yes** ☐ **No**

Please indicate relation to person and their diagnosis: _____

_____

_____

_____

_____

Level of Education: _____

Employment/Occupation: _____

Primary Source of Finances: _____

History of Homelessness? ☐ **Yes** ☐ **No** **If yes, when were they last homeless?** _____

Finances

Who will be responsible for financing PACT services: _____

Email address of person financially responsible: _____

Has the person responsible for finances been informed of the financial expectation? ☐ **Yes** ☐ **No**

Referrer Recommendations

How many months do you estimate this person needing PACT level of services? _____

Please select the top 5 types of PACT services that the person would benefit from the most:

☐ **Psychopharmacology**	☐ **Individual Therapy**	☐ **Social/Interpersonal Coaching**
☐ **Psychoeducation**	☐ **24/7 Crisis Support**	☐ **Vocational Support**
☐ **Medication Management**	☐ **Community Integration**	☐ **Wellness Coaching**
☐ **ADLs Coaching**	☐ **Substance Use**	☐ **Family Psychoeducation/Coaching**

Preferred start date: _____

Submit Form

Please contact the PACT Referral Coordinator Angelique Berman at 617.855.4292 with any questions.

Please complete and submit the PDF referral form by fax to **617.855.4264**, Attn: PACT Referral Coordinator.

Please attach any pertinent records (i.e., demographic sheet, copy of insurance card, admission/intake notes, psychosocial assessments, discharge summary, medication list, and recent progress notes).

For Staff Use Only: Appropriate for McLean PACT at this time? ☐ **Yes** ☐ **No**