DESCHUTES COUNTY BEHAVIORAL HEALTH OLDER ADULT PROGRAM REFERRAL FORM

Please Email to olderadultservices@deschutes.org or fax referrals to (541) 388-6617.

Do NOT save this document for re-use, always go the website for the most current one, otherwise your form may be rejected.

The Older Adult program offers behavioral health treatment to elders with complex psychiatric and medical conditions. Our multidisciplinary team provides specialty community-based services with the goal of stabilizing and supporting high-risk older adults. Screening, assessment, therapy, skills training, care coordination, and case management.

The older adults' team highly recommends that referred individuals are aware of and voluntarily want to participate in this program.

Individual information:	
Last Name:	First Name:
DOB:	
Address:	
Referral Information:	
Individual agrees to voluntary participate in OA program? ☐yes ☐no	
Date of Referral:	
Referral Name:	
Referring Agency:	
Best way to contact:	
PCP (if different from Referral Source):	

A. **Information in yellow requires further explanation. Individuals must meet at least one of each of the following criteria in each section to be considered for treatment (if applicant does not qualify, please see section B):**

AGE:	SPMI (serious and persistent mental illness):	Does the individual have a complex medical condition and one of the following?
☐65+*	☐Schizophrenia ☐Other Psychotic Disorder ☐ PTSD ☐Major Depression ☐ Bipolar ☐ Schizoaffective ☐Borderline Personality Disorder ☐Schizotypical Personality Disorder	☐Recent psychiatric hospitalization? If so, date of admission. (text box) ☐Have come into contact with multiple systems? (e.g. law enforcement, crisis services, adult protective services). ☐Requires specialty community-based services due to risk of psychiatric hospitalization, multiple system contacts, or loss of care placement?

Support Systems Involved? (Check all that apply):	Complex Medical Condition	Is dementia suspected?
☐Family or Friend ☐Adult Protective Services (APS) Case Worker ☐Aging & People with Disabilities (APD) Case Worker ☐Neurologist ☐Mental Health Therapist ☐Home Caregiver Group ☐Home Health ☐Specialty Doctors	☐Diabetes ☐Seizure Disorder ☐ Parkinson's ☐ Alzheimer's ☐ Autoimmune Disorder ☐ Cancer ☐Stroke ☐Heart Disease ☐ Lung Disease ☐ Mobility Disorder ☐ Other (please specify)	☐Yes☐ No **If Yes, recent MMSE or MoCA score:** **Has a referral to Neurology/neuropsychology been made?** ☐ Yes ☐No

B. Please complete this section.

Why are you making this referral and what would like us to know? (Presenting symptoms, level of distress, and impact on day-to-day life; onset and course of illness; current and past mental health treatment).
What is the proposed outcome of this referral?

Deschutes county Behavioral Health primarily works with those on the Oregon Health Plan (OHP). For those not on OHP, we offer an income-based sliding scale for behavioral health services not covered by other insurance plans.

OHP:	☒ YES# _ NO
Medicare:	☐ YES# _ NO

Would Individual like to be screened for any of the following? **

☐PASRR II

☐ Psychiatric Prescribing Consult

☐ Social Worker Consult.

Please attach any information that you think would be helpful for us to evaluate this referral i.e; Face sheet, current meds, insurance information, chart notes, etc... Please allow 7-10 business days for processing.

***Under 65 may be considered if the individual meets all other criteria.**

**** We will do our best to meet this need pending staff availability and workload management.**