**ATIBA Youth Intervention Services, LLC**

**Dedicated to Providing Mental Health Skill Building Services**

**Services to Qualified Recipients in the Commonwealth**

**Of Virginia**

**(804) 272-2277, FAX (804) 308-3168**

**Referral Screening Form**

DATE REFERRAL RECEIVED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRAL SOURCE: PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_ GENDER : M or F

SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAID NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 12 digits, all numbers – no letters

NAME OF PARENT/GUARDIAN (S):(if under 18)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_

(HM) PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (WK) PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESENTING PROBLEMS and NEEDS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Client must meet the following critera:**

1. Is the primary diagnosis schizophrenia/other psychotic disorder, Major Depressive Disorder- recurrent, or Bipolar I or II? [ ]  Yes [ ]  No [ ]  N/A
2. Does individular require individulized 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 persoal support system ; personal hygiene ; food preparation ; or money management? [ ] Yes [ ]  No
3. Does the individual have a prior history of any of the following: psychiatric hospitalization; residential crisis stablilization, Intensive Community Treatment (ICT) or Program of Asseertive Community Treatment ( PACT) services; placement in a psychiatric residential treatment facility ( RTC Level C) ; or Temporary Detention Order (TDO) evaluation as a result of or decompensation related to servious mental illness? [ ] Yes [ ]  No
4. Has the individual had a presecription for anti-psychotic, mood stabilizing, or anti-depressant medications within the 12 months prior to the assessment date? [ ] Yes [ ] No

Signature of person that the form was completed by Date