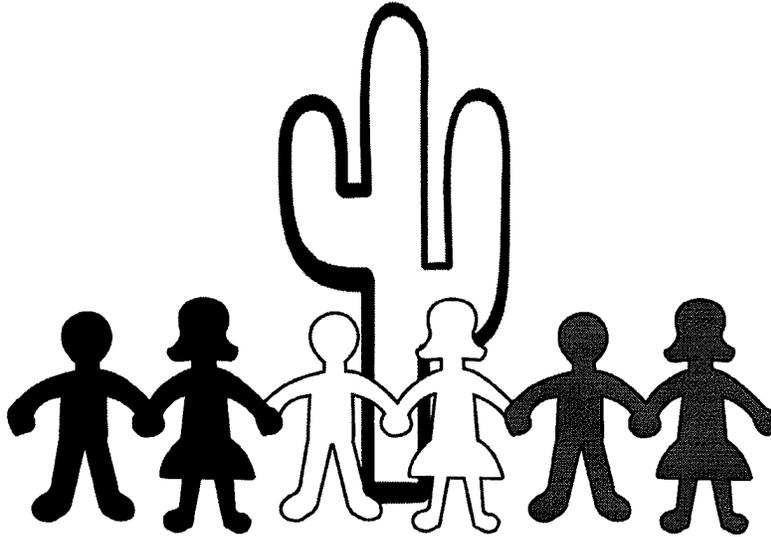


PLEASE PRINT AND COMPLETE ALL SECTIONS OF THE REFERRAL FORM.



Child and Adolescent Crisis Team Intervention Service (C.A.C.T.I.S.)

OFFICE PHONE: (412)864-5065

FAX: (412)864-5012

CACTIS provides mobile crisis services, telephone support services, home and school visits, and scheduled family visits. CACTIS also is an active participant in interagency and treatment team meetings to assist in developing a crisis plan.

In addition, CACTIS can provide 1-3 scheduled visits per week to the client/family to assess symptoms and medication side effects, provide family support and conduct preventative interventions while the child is waiting for admission to another level of care.

ADMISSION CRITERIA

- At risk for psychiatric hospitalization, re-hospitalization, or out-of-home placement (i.e., discharged from an inpatient unit within the past 6 weeks, history of multiple hospitalizations, and/or transitioning between two levels of care).
- Age 21 or under (18-21 year olds must be enrolled as a full-time high school student).
- Residents of Allegheny County.
- At least one DSM-IV Axis I diagnosis.
- Additional mental health services are in place or will be in place in the immediate future.

AFTER THE REFERRAL HAS BEEN MADE, THE PAGER NUMBER CAN BE GIVEN TO THE FAMILY.

CACTIS CRISIS PAGER NUMBER: (412) 393-9946

REFERRAL FORM FOR CACTIS SERVICES
PLEASE WRITE OR PRINT CLEARLY.
DATE OF BIRTH AND SS# ARE VERY IMPORTANT.

Date of Referral: _____

Referring Agency: _____ Referring Person: _____

Phone #: _____
(including area code)

Fax #: _____
(including area code)

SERVICES BEING REQUESTED:

MOBILE CRISIS, TELEPHONE SUPPORT

SCHEDULED VISITS (only appropriate if child is currently receiving no mental health treatment but is awaiting admission to a recommended level of care).

CLIENT'S NAME: _____

***CLIENT'S DOB:** _____

*Social Security Number: _____

WPIC MR# if known _____

Parent/Guardian Name: _____

*Home Phone: _____

Current Address: _____

Cell Phone #: _____

*Type of Behavioral Health Insurance: _____

*Insurance #: _____

EDUCATIONAL INFORMATION:

Current School Name: _____

School Address: _____

Grade _____ Type of placement _____ School Phone #: _____

School Contact Person and Title _____

***This information is mandatory on all referrals.**

Please describe reason(s) for referral: _____

CURRENT DSM-IV DIAGNOSES (including codes) from Referring Agency:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Medication(s): _____

Psychiatrist: _____

Mental Health Contact Person: _____

PSYCHOLOGICAL/PSYCHIATRIC HISTORY (List all inpatient admissions, including hospital name and dates, any partial programs, RTF placements, or any other pertinent out-of home placement such as Shuman Center, or shelter.) _____

Is child currently in treatment: YES NO

If NO, child is not eligible to receive CACTIS services unless he/she is on a waiting list to receive services. If child is on a waiting list for services, please indicate agency and anticipated start date of services. _____

If YES, indicate agency and level of treatment. _____

Signature of person completing form: _____

NOTE: A RELEASE FORM SHOULD ACCOMPANY THIS REFERRAL SO THAT CACTIS HAS PERMISSION TO CONTACT THE FAMILY TO SET UP A HOME VISIT TO EXPLAIN SERVICES.

Please fax referral form to: CACTIS Intake. Fax # 412-864-5012 or mail referral to:

**CACTIS Program
WPIC
333 North Braddock Avenue
Pittsburgh, PA 15208**