DMHAS ABI CONSULTATION REFERRAL

Return by Mail or Fax
To
DMHAS-ABI Community Integration Program
Beers Hall-P.O. Box 351
Middletown, CT 06457

Fax#860-262-5852

Revised 3/10/17

NOTE: "Asterisk" areas Required to Process Referral

Form 201

Client Information

* **Client Name:**	Maiden Name:	* **(circle)** **M** **F**
* **Address:** **City:** **St:** **Zip:**		Phone:
Age:	* **DOB:** Place Of Birth:	ROI Yes No
Race:	Religion:	* **Ethnicity:** ***Primary Language:**
Marital Status:	* **Veteran Status:** **Yes / No**	Education (Highest Grade)
DMHAS Client (circle) YES NO	Region	MPI # * **Social Security Number**
Employment Status:	Occupation:	
Employer(Name, Location, Phone):		

Income & Insurance

Type	I.D.	Amount

* Conservator (circle answer)

* **Person**	* **Estate**	* **None**
***Name:**		***Telephone**
***Address:**		

Clinicians/Agency

Current Programs	CLINICIANS/AGENCY	PHONE#

Receiving Services from

☐ DMHAS ☐ YAS ☐ DCF ☐ DSS

☐ DOC ☐ Nursing Home ☐ DDS

Name _____ Date _____

Clinical Information

***Person Making Referral:**	**Relationship:**	**Date:**
***Agency:**	*** Phone:**	**Fax:**

*** Reason For Referral (Please be specific)**

☐ **Consultation Services**	☐ **Advocacy**	☐ **ABI Substance Abuse**
☐ **Housing**	☐ **Assistance with Discharge**	
☐ **Community Residence Program**	☐ **ABI Verification**	

***Explain:**

*** Has this client sustained a brain injury? (Circle answer) See definition at end of form.**

Yes	**No**	**Unknown**

If yes, please describe, (date, type, loss of consciousness, injuries, etc.)

Was the client hospitalized as a result? (Circle answer)	Yes	No	Unknown
Where:			
Have you requested medical records? (Circle answer)	Yes	No	When:

History of Rehabilitation Services:

Psychiatric/Substance Abuse History:

Diagnoses:	Diagnosed by:	Date of Diagnosis:

Medications:

Allergies:

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*Client's Location at time of Referral:
☐ Living independently in the community
☐ Homeless (Name of shelter if applicable: _____)
☐ Inpatient psychiatric facility (Potential Discharge Date: _____)
☐ Inpatient medical facility (Potential Discharge Date: _____)
☐ DOC/Corrections (Potential Release Date: _____)
☐ Nursing home (Potential Discharge Date: _____)
☐ Inpatient Substance Abuse (Potential Discharge Date:_____)
Presenting Problem:

For DMHAS ABI Office Use Only

Program Response	Date:
Receiving Staff:	
Assigned Regions 1A 1B 2A 2B 3A 3B 4A 4B 5A 5B	

ABI/TBI DEFINITION

Any combination of focal and diffuse central nervous system dysfunction, both immediate and/or delayed, at the brain stem level and above. This dysfunction is acquired through the interaction of an external force such as a blow to the head or violent movements of the body; oxygen deprivation; infection; surgery; or vascular disorders not associated with aging. This dysfunction is not developmental or degenerative in origin.