|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Is Being Referred to** | | | | | | |  | |
| **Date:** &currentdate& | | | | | | |  | |
| **Diagnosis:** &CLTDGNDS5& &CLTDGNDS5RULEOUT& | | | | | | |  | |
| **ANSA:** &indalgoransa& | | **CANS B-5:** &indalgorcansB5& | | | | **CANS 5-17:** &indalgorcans& | | **Last ANSA/CANS:** &MRCANSA& |
| **Last Fin Aff:** &mrfinaf& | | **Last Mcd Review:** &mrhspprv& | | | | **Last Tx Plan Doc:** &mrtxplan& | | **MRO Pkg:** &mropkgdt& |
| **Programs Requested** | | | | **Modality**  Mental Health  Addictions  Primary Health Care | | | | |
| Care Management/Skills Training | | | | Wraparound | | | Sub-Acute | |
| Peer Support | | | | Employment | | | Residential | |
| Medication Training and Support | | | | Psychiatric Evaluation(Prescribers) | | | Addictions OP | |
| Mental Health OP | | | | Clubhouse |  | | Transitional Living | |
| Primary Health Care | | | | Integrated Care Team | | | Prescriber only services | |
| Psychological Testing | | | |  | | | | |
| **Reason for Referral** | | | | | | | | |
| **Notes (** medical conditions, risk factors, significant behavioral characteristics and any other significant clinical information) | | | | | | | | |
| **Action to be Completed by (Date):** | | | | | | | | |
| **Actions Taken**  Approved **Action Taken**        Treatment Plan Updated | | | | | | | | |
| Not Approved | **Reason for Denial** | |  | | | | | |
| **Provider’s Signature** | | | | | | | | |
| **Referring/Accepting Staff Signatures** | | | | | | | | |
| &STFCONSENTX& | | | | | | | | |