

**Department of Mental Health and Addiction Services (DMHAS)  
ABI Community Services: CONSULTATION REFERRAL**

1 of 2

Return by Mail or Fax (please Do Not email)

To

DMHAS-ABI Community Services  
Beers Hall 3<sup>rd</sup> Floor - P.O. Box 351  
Middletown, CT 06457

Fax#860-262-5852

Revised 12/12/2024

***NOTE: “Asterisk” areas Required to Process Referral***

Form 201

**Client Information**

<b>*Client Name:</b> (Incl. Maiden, If Applicable)			<b>* (sex at birth)</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Preferred Pronoun:</b>	
<b>*Address:</b>		<b>City:</b>	<b>St:</b>	<b>Zip:</b>	<b>*Phone:</b>
Age:	<b>*DOB:</b>	Race:	<b>*Ethnicity:</b>		<b>*Primary Language:</b>
Marital Status:		<b>*Veteran Status:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Education (Highest Grade):		<b>*Social Security Number:</b>
Employment Status:			Occupation:		
Employer (Name, Location, Phone):					
<b><u>Income &amp; Insurance</u></b>					
<b>Type</b>		<b>I.D.</b>	<b>Amount</b>		
<b>*Conservator:</b>					
<b>Person</b> <input type="checkbox"/>		<b>Estate</b> <input type="checkbox"/>	<b>None</b> <input type="checkbox"/>		
<b>* Name:</b>			<b>*Telephone:</b>		
<b>* Address:</b>					
<b><u>Clinicians/Agency</u></b>					
<b>Current Programs</b>		<b>CLINICIANS/AGENCY</b>			<b>PHONE#</b>
<b>Agency Receiving Services From:</b>					
<input type="checkbox"/> DMHAS	<input type="checkbox"/> YAS	<input type="checkbox"/> DCF	<input type="checkbox"/> DSS Entitlements		
<input type="checkbox"/> DOC	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> DDS	<input type="checkbox"/> DSS ABI Waiver		
<b>*Reason for Referral (Please be specific):</b>					
<input type="checkbox"/> Consultation Services	<input type="checkbox"/> Advocacy	<input type="checkbox"/> Assistance w/ Discharge	<input type="checkbox"/> ABI Substance Use Services	<input type="checkbox"/> ABI Verification	
<b><u>ABI/TBI DEFINITION</u></b>					
<p><i>An Acquired Brain Injury (ABI) is an injury to the brain that has occurred after birth, which results in any combination of focal and diffuse central nervous system dysfunction, both immediate and/or delayed at the brain stem level and above. This dysfunction of the central nervous system is acquired through the interaction of any external force and the body including blows to the head and violent movements of the body (Traumatic Brain Injury); as well as through oxygen deprivation; infection; toxicity; surgery; and vascular disorders not associated with aging. This dysfunction is not congenital, developmental, or degenerative.</i></p>					

An Acquired Brain Injury (ABI) is an injury to the brain that has occurred after birth, which results in any combination of focal and diffuse central nervous system dysfunction, both immediate and/or delayed at the brain stem level and above. This dysfunction of the central nervous system is acquired through the interaction of any external force and the body including blows to the head and violent movements of the body (Traumatic Brain Injury); as well as through oxygen deprivation; infection; toxicity; surgery; and vascular disorders not associated with aging. This dysfunction is not congenital, developmental, or degenerative.

\*\*\*Please complete page 2\*\*\*

<b>*Person Making Referral:</b>		Relationship:	Date:
<b>*Agency:</b> (If yes, plz attach ROI)	<b>*Phone:</b>	<b>*Fax:</b>	
<b>*Is client aware of this referral?</b>			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
Presenting issue:			
History of head injury:			
Was the client hospitalized as a result? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Rehabilitation facility if attended:			
Mental Health / Substance use history:			
Diagnoses:			
Diagnosed by:		Date:	
Medications (can attach list):			
Allergies:			
<b>*Client's Location at time of Referral (needed for assignment of case):</b>			
<input type="checkbox"/> Living independently in the community <input type="checkbox"/> Homeless - Name of shelter if applicable: <input type="checkbox"/> Inpatient Psychiatric Facility - <b>Potential Discharge Date:</b> <input type="checkbox"/> Inpatient Medical Facility - <b>Potential Discharge Date:</b> <input type="checkbox"/> DOC/Corrections - <b>Potential Discharge Date:</b> <input type="checkbox"/> Nursing Home - <b>Potential Discharge Date:</b> <input type="checkbox"/> Residential Substance - <b>Potential Discharge Date:</b>			
For DMHAS ABI Office Use Only			
Program Supervisor:		Assign Date:	
Assigned Region: <input type="checkbox"/> 1 <input type="checkbox"/> 2A <input type="checkbox"/> 2B <input type="checkbox"/> 3A <input type="checkbox"/> 3B <input type="checkbox"/> 4A <input type="checkbox"/> 4B <input type="checkbox"/> 5A <input type="checkbox"/> 5B			
Comments:			