Department of Mental Health and Addiction Services (DMHAS)

ABI Community Services: CONSULTATION REFERRAL

Return by Mail or Fax (please Do Not email)
To
DMHAS-ABI Community Services
Beers Hall 3rd Floor - P.O. Box 351
Middletown, CT 06457

Fax#860-262-5852

Revised 10/30/23

NOTE: "Asterisk" areas Required to Process Referral

Form 201

Client Information

***Client Name:** (Incl. Maiden, If Applicable)		* (sex at birth) ☐ M ☐ F	*Preferred Pronoun:*	
***Address:**	**City:**	**St:**	**Zip:**	***Phone:**
Age: ***DOB:**	Race:	***Ethnicity:**	***Primary Language:**	
Marital Status:	***Veteran Status:** ☐Yes ■No	Education (Highest Grade):	***Social Security Number:**	
Employment Status:	Occupation:			
Employer (Name, Location, Phone):				

Income & Insurance

Type	I.D.	Amount

*Conservator:

Person ☐ **Estate** ☐ **None** ☐

*** Name:** ***Telephone:**

*** Address:**

Clinicians/Agency

Current Programs	CLINICIANS/AGENCY	PHONE#

Agency Receiving Services From:

☐ DMHAS ☐ YAS ☐ DCF ☐ DSS Entitlements
☐ DOC ☐ Nursing Home ☐ DDS ☐ DSS ABI Waiver

*Reason for Referral (Please be specific):

☐ Consultation Services ☐ Advocacy ☐ Assistance w/ Discharge ☐ ABI Substance Abuse ☐ ABI Verification

ABI/TBI DEFINITION

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

***Person Making Referral:**	Relationship:	Date:
***Agency:** (If yes, plz attach ROI)	***Phone:**	***Fax:**

***Is client aware of this referral?**

☒ YES ☐ NO

Presenting Problem:

History of head injury:

Was the client hospitalized as a result? ☐ Yes ☐ No ☒ Unknown

Rehabilitation facility if attended:

Mental Health / Substance use history:

Diagnoses:

Diagnosed by: Date:

Medications (can attach list):

Allergies:

***Client's Location at time of Referral (needed for assignment of case):**

☐	Living independently in the community w/
☐	Homeless - Name of shelter if applicable:
☐	Inpatient Psychiatric Facility - **Potential Discharge Date:**
☐	Inpatient Medical Facility - **Potential Discharge Date:**
☐	DOC/Corrections - **Potential Discharge Date:**
☐	Nursing Home - **Potential Discharge Date:**
☐	Inpatient Substance Abuse - **Potential Discharge Date:**

For DMHAS ABI Office Use Only

Program Supervisor: Assign Date:

Assigned Region: ☐1 ☐2A ☐2B ☐3A ☐3B ☐4A ☐4B ☐5A ☐5B

Comments: