103 D West Main Street
Carrboro, NC 27510

CLUBNOVA

919.968.6682 (phone)
919.968.2522 (fax)
www.clubnova.org
pmazzei@clubnova.org

Referral Checklist

In order to make an informed decision about an individual referral to Club Nova, we must have all of the information listed below. Please fill out the referral form on page two and complete it with the **signature of a MD**. When compiling the necessary referral information, please check each item on the following list and attach this sheet to the top of the completed packet**. We will not be able to process the referral if we do not have all of the information.** If you have any questions or need more information, please contact staff in the Membership Unit at 919.968.6682 or *pmazzei@clubnova.org*. Thank you.

ALL REFERRALS MUST INCLUDE:

Pg. 2 **[ ]** **Referral form** (with signature). Please include complete diagnostic information, including the ICD 10 codes and known allergies.

Pg. 3 – 4 **[ ]** **Authorization to disclose** PHI.

Pg. 5 – 17 **[ ]** **Comprehensive Clinical Assessment (completed in last 5 years), including a recommendation for Psychosocial Rehabilitation and Supported Employment.** Many clinicians include us in the following way: "PSR up to 48 hours per week, Supported Employment up to 18 hours per month."
If no recent CCA is available, please complete the one included in this packet. (Pg. 5 – 17)

[ ] **Service Notes for the last three months.**

[ ] Transportation needs/concerns:
_____
_____

[ ] Hospital Discharge/Admission if available.

[ ] IPRS Target Population: __AMI __AMSRE __other(_____)

[ ] **Insurance**_____ Recipient ID_____

If the above criteria are met and membership is offered, a 30-day preliminary PCP (Person Centered Plan) will be created for the potential member.

Please send/fax information to: Peter Mazzei
fax: 919.968.2522
Or email to: pmazzei@clubnova.org

103 D West Main Street
Carrboro, NC 27510

CLUB NOVA

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919.968.2522 (fax)
www.clubnova.org

Referral Source: _____ Date: _____
Agency: _____ Phone: _____
Address: _____ Email: _____
_____ Fax: _____

Client's Full Name: _____ Preferred Name: _____
Social Security #: _____
Medicaid ID #: _____
DOB: _____ Race: _____ Ethnicity: _____ Sex: ____
Client's Address: _____
_____ Phone: _____
_____ E-Mail: _____

Current living arrangement: ____w/family ____Independent Apt/House (____ Alone ____ w/ roommate)
____Group Home ____Assisted Living ____Other (_____)

Family Contacts: _____ Phone: _____
Therapist: _____ Phone: _____
Psychiatrist: _____ Phone: _____
Case Manager/CST: _____ Phone: _____
Primary Care Physician: _____ Phone: _____
Other Service Providers: _____ Phone: _____

Diagnosis: Medications:
Axis I: _____ _____
Axis II: _____ _____
Axis III: _____ _____
Axis IV: _____ _____
Axis V: GAF_____ _____

History of Adherence: _____

Known Allergies: _____

Reason for Referral: _____
_____

Please list all services the client is currently receiving: _____
_____

Check all that apply to client: ____Employed ____SSI ____SSDI
____Housing Assistance ____Food Stamps ____Medicaid ____Medicare
____ACTT Client ____Other Income/Support (_____)

History of substance abuse: _____
_____Current Clean Time: _____

Other information: _____
_____

ORDER FOR SERVICE: I order up to 48 hours per week of psychosocial rehabilitation and 18 hours per month of supported employment services for this client.

Signature (MD): _____ **Date:** _____

Please fax, mail or deliver information to:
Club Nova Community, Inc.
Attn: Membership Unit Staff
Fax (919) 968-2522
PO Box 1346
Carrboro. NC 27510

Authorization for Disclosure of Protected Health Information

The client must always be given a copy of this form after signing. **Complete as needed. Use for disclosing information to other agencies or requesting information from other agencies.**

In the following cases, minors have the right to release information without parent's signature; these minors have the same rights as adults:

1. Emancipated minors
2. Minors receiving Substance Abuse treatment
3. Minors receiving treatment without parental consent.

I, _____, hereby authorize the release of information

TO/FROM: (Please Circle) Club Nova Community Inc 103 D West Main Street Carrboro, NC 27510 919-968-2522

Site Address **(must be specified)** Street City State Zip Code Fax

TO/FROM: (Please Circle)

1. _____

Person/Agency Street City State Zip Code Phone/Fax

2. **Cardinal Innovations 201 Sage Road Chapel Hill, NC 27514-6510. (919) 913-4000**

3. _____

4. _____

5. _____

for the purpose of assessment, treatment planning, referral, and/or coordination of services. I have been advised that Club Nova may charge a reasonable fee for the costs of copying, mailing or other supplies associated with any request for copies.

Please **initial** below indicating which documentation regarding your treatment may be released and/or exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

Other Agency Documentation

X_____Assessment/diagnoses X_____Service plan(s) X_____Physician's Orders/medication history

X_____Treatment history X_____Medical history X_____Educational history

X_____Social/developmental history X_____Discharge summary X_____Evaluation(s): Comprehensive Clinical Assessment/Physician's Update

_____Service note(s), dates:_____through_____ _____

_____Other (specify) _____

_____Release of records is authorized even if such records contain information related to substance abuse.

_____Release of records is authorized even if such records contain information related to HIV/AIDS.

X_____In addition to the initial disclosure of identified information I authorize periodic exchange of information between Club Nova and the noted agencies.

Club Nova Generated Documentation

X_____Referral/Screening Form X _____Service Plan _____Notification of Intervention Use

X_____Admission Assessment X_____Index of Attendance _____Physician's Orders/Medication history

_____Diagnostic Report(s) _____Behavior Intervention Plans _____Medication Administration history

X_____Transfer/Discharge Summary _____Evaluation(s) (circle) Psychological

_____Service Note(s) dates:_____through_____ Psychiatric Speech / OT / PT

_____**Other (specify)** Diagnosis, Provider Agencies, Service Types, Codes, Units approved, Authorization dates

_____Release of records is authorized even if such records contain information related to substance abuse

_____Release of records is authorized even if such records contain information related to HIV/AIDS.

X_____In addition to the initial disclosure of identified information I authorize periodic exchange of information between Club Nova and the noted agencies.

PLEASE REFER TO PAGE 2 FOR FURTHER INFORMATION AND SIGNATURE(S)

I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

I understand what information will be released, the purpose of the release of the information, and that there are statutes and regulations protecting the confidentiality of the information. Club Nova's NOTICE OF PRIVACY PRACTICES describes the circumstances where disclosure is permitted or required by state or federal laws.

I understand the terms of this release and voluntarily give my authorization. I understand that I may refuse to sign this authorization form and understand that Club Nova will not condition my treatment, or any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this authorization. I further understand that I may revoke my authorization by giving written notice to my service provider or to the Quality Improvement Representative of Club Nova. Such revocation does not affect the validity of the consent for information disclosed/released prior to the revocation. If not revoked earlier, this authorization expires automatically one year from the date it is signed or upon _____, whichever is earlier.

(date or event specified by client or dictated by the purpose of the authorization)

Signed_____ Date_____

(Specify if signature is that of client, parent(s), legal guardian, or personal representative)

Witnessed_____ Date_____

(Witness signature is required only if the form is sent out of state **or** if the above client signature has been signed by a mark)

This authorization is hereby revoked upon the signed and dated request of the client as noted below:

Signed_____ Date_____

(Client signature)

The client has notified me verbally that he/she wishes to revoke this authorization with an effective date of:

Signed_____ Date _____

(Staff signature)

THE INFORMATION RELEASED IS CONFIDENTIAL AND REDISCLOSURE IS PROHIBITED

EXCEPT AS AUTHORIZED BY G.S. 122C-53 THROUGH G.S. 122C-56.

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

A. PRESENTING PROBLEM AND/OR REASON FOR ADMISSION: (may include chief complaint, stressors, symptoms, history of illness).

Chief Complaint	
Stressors	
Symptoms	
History of Present Problem	

B. PSYCHIATRIC INFORMATION: Past and current treatment history.

Onset of Illness:
Previous Hospitalizations:
Previous Outpatient Treatment:
Diagnosis Given:
Medications Taken:
History of Compliance:
Suicidal Ideations or Attempts:
Homicidal Ideations or Attempts:
Non-suicidal Self-Harm:

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

C. SOCIAL	STRENGTHS	CHALLENGES/BARRIERS
Family (include marital/partner)		
Community Support System (Friends, etc.)		
Employment		
Independent Living Skills (including Financial, Activities of Daily living, Housing, Transportation, etc.)		
Strengths/Preferences/Interests Skills		

D. EDUCATION

Highest Grade Completed:
Learning Abilities/Strengths:
Educational Problems:
Behavior Problems in School:
Repeated Grades? If so, which?
Social Interactions (peers/teachers):
Suspensions:
Expulsions:
Other Educational Services (Specify if individual is interested in pursuing further education):

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

E. INDEPENDENT LIVING SKILLS: CHECK ☐IF NO NEEDS IN THIS AREA.

Needs assistance with employment:
Needs assistance with finances (budgeting, banking, entitlements):
Needs assistance in improving housing:
Needs assistance in accessing transportation services:

F. RESIDENTIAL/HOUSING/ENVIRONMENT: CHECK ☐ IF NO NEEDS IN THIS AREA. (PLEASE ADDRESS STRENGTHS)

Ever Homeless:	In last year, number of residences:
Current Living Situation:	Lives with whom (include ages):
Strengths related to current living situation:	
Concerns with maintaining stable housing:	

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

G. FAMILY HISTORY:

Relevant childhood history:
Guardianship status (person, estate, limited) – if applicable:
Family history of mental illness/substance abuse treatment:
Siblings:
Current Spouse/Significant Other:
Children/Step-Children:
Relational Issues with Family (Include family's potential involvement with treatment):

H. DEVELOPMENTAL HISTORY: CHECK ☐IF NO SIGNIFICANT RISK FACTORS IDENTIFIED.

Prenatal history and birth (include pre-natal exposure to alcohol, tobacco, and other drugs):
Developmental milestones appropriately met:
Language/speech/hearing/visual functioning:

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

I. SOCIAL HISTORY:

Interactions with peers, co-workers, etc.:
Conflictual Relationships:
Cultural and Religious needs/preferences:
Concerns/Issues relative to sexual orientation:

J. EMPLOYMENT: Currently Employed: ☐Yes ☐No (☐PT and/or ☐Full time): Check ☐, if no employment needs identified.

Current Position:	SSDI claim status (if applied):
Satisfaction with current employment situation. (If not employed, is that by choice? Explain.)	
Employment History, including reasons for job changes:	
Barriers/Challenges to improving current situation, if desired:	

I. MILITARY: Check ☐, if no military service.		
Branch/Rank:	Years Served:	Reason for Discharge:
Service Connected Disability?		

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

K. RELEVANT LEGAL INFORMATION: Check here ☐ if no past or current legal issues related to consumer.

Current Charges:	
Current Probation Requirements:	
Probations Officer/Court Counselor:	Attorney:
Age of first arrest:	
Previous Charge(s):	
Previous Conviction(s):	
Incarceration History:	

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

L. RELEVANT MEDICAL INFORMATION:

Family doctor:_____

Present health concerns/strengths:

Relevant Medical History

Any history of head injury? Specify if open or closed head injury, note if loss of consciousness:	
Allergies: Environmental, medications, food:	
Vision:	Hearing:
Teeth:	Skin:
Seizures (type and frequency):	
Developmental Disabilities: ☐Does not apply. ☐Does apply-please complete DD Addendum.	
Current Medications:	

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

M. Mental Status Examination (Current)

Appearance
☐Well Groomed
☐Obese
☐Overweight
☐Underweight
☐Emaciated
☐Slim
☐Bizarre hair style
☐Unshaven
☐Scars
☐Tattoos
☐Disheveled
☐Soiled
☐Body odor
☐Halitosis
☐Underdressed
☐Overdressed
☐Bizarre
☐Other:

Motor Activity
☐Unremarkable
☐Limp
☐Shuffle
☐Assisted
☐Odd gait
☐Tremulous
☐Restlessness
☐Hyperactivity
☐Gestures
☐Twitches
☐Stereotypical
☐Psychomotor agitation
☐Psychomotor retarded
☐Sluggish

Speech
☐Unremarkable
☐Rapid
☐Slow
☐Slurred
☐Mumbled
☐Stutters
☐Overly talkative
☐Taciturn
☐Loud
☐Whispered
☐Hesitant
☐Monotonous
☐Stereotypical
☐Lack of spontaneity
☐Echolalia
☐Perseverative

Attitude to Examiner
☐Appropriate
☐Playful
☐Ingratiating
☐Friendly
☐Cooperative
☐Guarded
☐Attentive
☐Frank
☐Indifferent
☐Evasive
☐Defensive
☐Hostile
☐Seductive
☐Suspicious
☐Other:

Mood
☐Normal
☐Ecstatic
☐Euphoric
☐Expansive
☐Elated
☐Fearful
☐Anxious
☐Depressed
☐Grieving
☐Angry
☐Irritable
☐Optimistic
☐Pessimistic

Affect
☐Appropriate
☐Inappropriate
☐Flat
☐Blunted
☐Restricted
☐Labile

Memory
☐Immediate
☐Recent
☐Remote

Insight
☐Complete denial
☐Slight awareness
☐Blames others
☐Blames self
☐Intellectual insight but few changes likely
☐Emotional insight, understanding change can occur

Content of Thought
☐Normal
☐Ideas of reference
☐Paranoid trends
☐Preoccupations
☐Obsessions/Compulsions
☐Rituals
☐Delusions
☐Phobic
☐Depersonalization
☐Homicidal Ideation
☐Suicidal Ideation

Thought Form
☐Normal
☐Tangential
☐Illogical thinking
☐Circumstantial
☐Loose associations
☐Slowness in associations
☐Incoherence
☐Derailment
☐Flight of ideas
☐Blocking
☐Evasiveness

Perception
☐Illusions
☐Auditory hallucinations
☐Visual hallucinations
☐Other hallucinations

Orientation
☐Person
☐Place
☐Time
☐Situation

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

Additional comments: (further explanation of boxes on previous page):

N. CURRENT RISK: Check ☐ if No suicidality/homicidality present

Suicidal Intent/Ideation	Plan:
	Available Means:
	Other:
Homicidal Intent/Ideation	Plan:
	Available Means:
	Other:

Non-Suicidal Self-Harm	☐Scratching ☐Burning ☐Cutting ☐Other Most recent incident: Method: Date:

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

1. History of Risk

Previous Suicidal/Homicidal Attempts:

2. Exposure to Trauma Violence

☐Neglect ☐Emotional Abuse	☐Physical Abuse ☐Sexual Abuse	☐Domestic Violence (victim of or witness to) ☐Other (please specify):
Provide detail (specify ages and perpetrators):		

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

O. Symptom Checklist (past and current – must be supported by information in other sections):

Depressive Symptoms
☐Depressed Mood
☐Loss or interest or pleasure
☐Weight loss/gain
☐Decreased concentration
☐Excessive guilt
☐Feelings of wordlessness
☐Insomnia
☐Hypersomnia
☐Decreased energy
☐Sadness
☐Crying
☐Irritability
☐Fatigue

Manic Symptoms
☐Grandiosity
☐Decreased need for sleep
☐Hypersexual
☐Racing Thoughts
☐Restlessness
☐Euphoria
☐Distractibility
☐Spending Sprees
☐Increase in goal directed activity

Conduct/Legal Problems
☐Oppositional defiant
☐Lying
☐Stealing
☐Running away from home
☐Assaults
☐Fighting
☐Property destruction
☐Fire Setting
☐Gang Involvement
☐Arrests
☐Convictions
☐Family desertion
☐Exhibitionism
☐Sexual Acting Out
☐Other

Psychosis
☐Auditory Hallucinations
☐Visual Hallucinations
☐Delusions
☐Paranoid Thinking
☐Ideas of Reference
☐Other

Anxiety Symptoms
☐Anxiety
☐Avoidance
☐Panic Attacks
☐Obsessions
☐Compulsions
☐Nightmares
☐Somatic Complaints
☐Intrusive Thoughts
☐Flashbacks
☐Bedwetting
☐Dissociative Episodes
☐Other

Attention Symptoms
☐Fails to Finish Things
☐Cannot Concentrate
☐Hyperactive
☐Fidgets
☐Difficulty following directions
☐Acts impulsively
☐Daydreams
☐Talks out of turn
☐Messy/Disorganized
☐Inattentive
☐Fails to carry out tasks
☐Easily Distracted
☐Other

Sleep
☐Increased
☐Decreased
☐Restless
☐Difficulty falling asleep
☐Early Morning Awakening

Appetite
☐Increased
☐Decreased
☐Weight Loss
☐Weight Gain
☐No Change

Other Biological Functions
☐Amenorrhea
☐Enuresis
☐Encopresis
☐Decreased Libido
☐Increased Libido
☐Other

P. RELEVANT SUSTANCE USE/ABUSE INFORMATION:

☐Check here if no current or past use of substance is reported:

Note: for diagnostic assessment, substance abuse specialist must complete this section. If substance abuse, diagnosis is present.

Drug Use	Age at 1st Use	Age at Reg. Use	Current Pattern Frequency & Average Use	Method of Administration	Last Use
Nicotine					
Alcohol					
Marijuana					
Cocaine/Crack					
Amphetamines					
Hallucinogens					
Ecstasy/Other					
Inhalants					
Heroin					
Barbiturates					
Other					

Q. CLINICAL IMPRESSION/INTERPRETIVE

R. DIAGNOSIS

I._____

II._____

III._____

IV._____

V._____

Comprehensive Clinical Assessment

Client Name:_____
Medicaid #:_____
Medical Record #:_____
Date of Assessment:_____

S. TARGET POPULATION:

T. LIFE DOMAINS AFFECTED

U. RECOMMENDATIONS

Print Name **Signature/Title** **Date**