DHHS
MONTGOMERY COUNTY

INTENSIVE TEAM MEETING (ITM) - REFERRAL FORM

To schedule an ITM, complete typed form and email password protected form to:
DHHS.PACS@montgomerycountymd.gov

REFERRING SERVICE AREA INFORMATION		
Referral Service Area/ Program:		Date:
DHHS Employee Referring:	Phone:	Email:
Supervisor:	Phone:	Email:
Lead Case Manager: *(For contract programs only)	Phone	Email
Reason(s) for Intensive Team Meeting:		
Meeting Goal(s):		
1. Have you discussed this case with your supervisor? ☐ Yes ☐ No		
2. What is this meeting type? (Choose One) ☐Initial ITM ☐ Follow Up ITM ☐ Barrier Resolution Meeting		
3. Will the client participate in meeting: ☐ Yes ☐ No (Please describe below why not)		
3a. If yes to 3 above, will referring staff be providing or coordinating transportation for the client and/or family members to attend? ☐ Yes ☐ No		
4. If providers need to confer prior to the client's arrival, indicate how much time is needed. ☐ ½ hour ☐ 1 hour		
5. Will a telephone conference line be needed for the meeting? ☐ Yes ☐ No		
6. Is an interpreter needed for this meeting? ☐ Yes ☐ No (If yes, indicate language needed:)		
7. Is there a signed release(s) in place for all providers and contacts who will be invited to the meeting? ☐ Yes (If yes, please include with referral) ☐No (If no, why not?)		
8. **ITM's are held Thursdays: 10am - 12pm, 1pm-3pm or 2pm - 4pm at 401 Hungerford Drive Rockville, MD 20850 unless otherwise requested.** Please provide 3 potential Thursday dates for your ITM: (1) (2) (3)		
9. Are you requesting your ITM be held at another location than 401 Hungerford Drive? ☐ Yes ☐ No		
9a. If yes to 9 above, provide the full address of requested location including room number and parking details: 9b. Is there a phone available in the meeting room? ☐ Yes ☐No		

CLIENT INFORMATION			
Name (**First LAST**):	Date of Birth:	Gender:	eICM ID#:
	Age:		
Diagnosis (Medical & Psychiatric if applicable):			

CURRENT/PAST SERVICES *(Please check eICM for comprehensive list)*

List contact information for all known client service providers.

Program:	Contact Person:
Is staff attendance required: ☐Yes ☐No (Please provide contact information)	E-mail: Phone:
Program:	Contact Person:
Is staff attendance required: ☐Yes ☐No (Please provide contact information)	E-mail: Phone:
Program:	Contact Person:
Is staff attendance required: ☐Yes ☐No (Please provide contact information)	E-mail: Phone:
Program:	Contact Person:
Is staff attendance required: ☐Yes ☐No (Please provide contact information)	E-mail: Phone:

HOUSEHOLD INFORMATION

Please list contact information for family/ household members

Name (**First LAST**):	Relationship to client:	Age:	Lives with client: ☐ Yes Should attend*: ☐ Yes
Services Household Member Receives:		Language Preference:	Email: Phone(s):
Name (First LAST):	Relationship to client:	Age:	Lives with client: ☐ Yes Should attend*: ☐ Yes
Services Household Member Receives:		Language Preference:	Email: Phone(s):
Name (First LAST):	Relationship to client:	Age:	Lives with client: ☐ Yes Should attend*: ☐ Yes
Services Household Member Receives:		Language Preference:	Email: Phone(s):
Name (First LAST):	Relationship to client:	Age:	Lives with client: ☐ Yes Should attend*: ☐ Yes
Services Household Member Receives:		Language Preference:	Email: Phone(s):
Name (First LAST):	Relationship to client:	Age:	Lives with client: ☐ Yes Should attend*: ☐ Yes
Services Household Member Receives:		Language Preference:	Email: Phone(s):

**Referring staff confirms that any family/household member who should attend ITM will be invited by the referring staff:* ☐ Yes ☐ No

ADDITIONAL SERVICE PROVIDERS/ OTHER CONTACTS TO BE INVITED TO THE MEETING *Please list contact information for all providers and other contacts- add additional lines if needed.*		
Name (First, LAST)	Service Area/Program/Partner/ Relationship to Client	Email and Phone (Required)
		E-Mail: Phone:
		E-Mail Phone:
		E-Mail Phone
		E-Mail: Phone:
		E-mail: Phone:
		E-Mail: Phone:
		E-Mail: Phone:
		E-Mail: Phone:

BRIEF CASE HISTORY *Please include a detailed, typed case history below (one-page max)*

FOR OFFICIAL USE ONLY	
Facilitator name and phone(s)	
Location, room number and time	
Interpreter name and phone(s)	

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