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**INTENSIVE TEAM MEETING (ITM) - REFERRAL FORM**

**To schedule an ITM, complete typed form and email encrypted :** DHHS.PACS@montgomerycountymd.gov

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| **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 [ ]  FIM/TY |
| 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 and times for your ITM (1 week minimum notice):(1) (2) (3)  |
| 9. Are you requesting your ITM be held at another location other 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 |

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

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| **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: [ ]  YesShould attend\*: [ ]  Yes |
| Services Household Member Receives: | Language Preference: | Email: |
| Phone: |
| Name (First LAST): | Relationship to client: | Age: | Lives with client: [ ]  YesShould attend\*: [ ]  Yes |
| Services Household Member Receives: | Language Preference: | Email: |
| Phone: |
| Name (First LAST): | Relationship to client: | Phone(s): | Lives with client: [ ]  YesShould attend\*: [ ]  Yes |
| Services Household Member Receives: | Language Preference: | Email: |
| Phone: |
| Name (First LAST): | Relationship to client: | Age: | Lives with client: [ ]  YesShould attend\*: [ ]  Yes |
| Services Household Member Receives: | Language Preference: | Email: |
| Phone: |
| Name (First LAST): | Relationship to client: | Age: | Lives with client: [ ]  YesShould attend\*: [ ]  Yes |
| Services Household Member Receives: | Language Preference: | Email: |
| Phone: |
| *\*Referring staff confirms that any family/household member will be invited by the referring staff:* [ ]  Yes [ ]  No |

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| **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) |
|  |  | Email:  |
| Phone:  |
|  |  | Email: |
| Phone: |
|  |  | Email: |
| Phone: |
|  |  | Email: |
| Phone: |
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| Phone: |

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| **BRIEF CASE HISTORY***Please include a detailed, typed case history below (one-page max)* |
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| **FOR OFFICIAL USE ONLY** |
| Facilitator name and phone(s) |  |
| Location, room number and time |  |
| Interpreter name and phone(s) |  |