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

**To schedule an ITM, complete typed form and email encrypted :** [DHHS.PACS@montgomerycountymd.gov](mailto: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:  Yes  Should attend\*:  Yes |
| Services Household Member Receives: | | Language Preference: | Email: |
| Phone: |
| Name (First LAST): | Relationship to client: | Age: | Lives with client:  Yes  Should attend\*:  Yes |
| Services Household Member Receives: | | Language Preference: | Email: |
| Phone: |
| Name (First LAST): | Relationship to client: | Phone(s): | Lives with client:  Yes  Should attend\*:  Yes |
| Services Household Member Receives: | | Language Preference: | Email: |
| Phone: |
| Name (First LAST): | Relationship to client: | Age: | Lives with client:  Yes  Should attend\*:  Yes |
| Services Household Member Receives: | | Language Preference: | Email: |
| Phone: |
| Name (First LAST): | Relationship to client: | Age: | Lives with client:  Yes  Should 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: |
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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) |  |