

**MILESTONE, LLC**  
**MENTAL HEALTH SKILLS BUILDING**

613 High St., Portsmouth, VA 23704

Phone: (757) 531-7891

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[www.milestoneagencyva.com](http://www.milestoneagencyva.com)

**Mental Health Skills Building Referral and Prescreening**

**Client Information (please print)**

Name \_\_\_\_\_ Birth Date: \_\_\_\_\_ (m/dd/yyyy)

Contact number \_\_\_\_\_ Gender: M/F

Medicaid#: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Address: \_\_\_\_\_

PCP Name/Number: \_\_\_\_\_

**Serviceable Problems: (circle)**

**Functioning Skills**

Money management  
Attending medical appointments  
Monitoring health  
Medication compliance

**Social Functioning**

maintain close relationships  
understanding social rules of conduct  
involved in social/recreational/religious activities

**Cognitive Functioning**

learning new skills  
completing tasks  
prioritizing activities  
read/write

**Sleep Patterns**

Difficulty falling asleep

Difficulty staying asleep

Difficulty staying awake

Nightmares

**Eligibility Criteria**

**Please check Yes or No to indicate if the following criteria is met by individual seeking services**

1. The client has one of the following as a primary Axis I DSM diagnosis:

YES

NO

(a) Schizophrenia or other psychotic disorder as set out in the DSM OR

(b) Major Depressive Disorder-Recurrent: Bipolar I; or Bipolar II OR

(c) Any other Axis I mental health disorder that a physician has documented specific to the identified individuals within the past year to include the following:

i. that is a serious mental illness

ii. results in severe and recurrent disability

iii. produces functional limitations in the individual's major life activities which are

iv. documented in the individual's medical record

the individual requires individualized training in order to achieve or maintain independent living in the community

2. The client shall require training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management.

Yes

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No

3. Prior history of any of the following: psychiatric hospitalization; residential crisis stabilization; Intensive Community Treatment (ICT) or Program of Assertive Community (PACT) services; placement in a psychiatric residential treatment facility (RTC Level C), or Temporary Detention Order (TDO) evaluation as a result of decompensation related to serious mental illness

Yes

No

4. A prescription for anti-psychotic, mood stabilizing, or anti-depressant medications within the past 12 months prior to the assessment date,

Yes

No

Screening recommendation and disposition plan:

\_\_\_\_\_Based upon the above information and information obtained, applicant is appropriate for the program and will be admitted.

\_\_\_\_\_Based upon the above information and information obtained, applicant is NOT appropriate for the program and will be recommended for more appropriate services to meet his/her needs.

Recommendations are: \_\_\_\_\_

**Professional Authorization (person completing referral form)**

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Date: \_\_\_\_\_