CRISIS INTERVENTION & RESPONSE PROGRAM
Addictive and Mental Disorders Division - State of Montana

FAX COVER SHEET

DATE Submitted: _____

TO: AMDD Benefit Management Team
Telephone: 406-444-3964 Fax: 406-444-7391

FROM: Crisis Care Manager: _____

Telephone: _____ Fax: _____

Email: _____

RE: Crisis Intervention & Response Program (CIR)

pages (including cover): _____

Instructions:

Please complete the following two pages, and fax or email to the AMDD Benefit Management Team, using this page as the cover sheet.

ONLY USE FOR 72 HOUR CRISIS INTERVENTION AND RESPONSE – This form would only be used for screenings done by a CIR

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CLIENT INFORMATION

LAST NAME: **FIRST NAME:**

ADDRESS: **CITY:** **ZIP CODE:**

SSN: **D.O.B.:** **COUNTY:** **GENDER:** ☐ **M** ☐ **F**

Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Domestic Partnership

Race / Ethnicity: ☐ Caucasian ☐ Native American ☐ Hispanic ☐ Black ☐ Unknown

PROVIDER INFORMATION

Date(s) of Service:

Mental Health Practitioner Name: Telephone Number:

CIR Agency & Name: City:

Telephone Number: Fax Number:

ELIGIBILITY ASSESSMENT

Does this individual's situation meet the definition of Crisis? ☐ **Yes** ☐ **No**
If yes - Please specify:

Referral for Crisis Intervention services made by:

☐ Ambulance / EMT	☐ Self	☐ Hospital ER / ED
☐ Family / Friend	☐ Homeless Shelter	☐ Probation / Parole / Prerelease
☐ Law Enforcement	☐ Nursing Home	☐ Crisis Facility / Program

☐ Jail (please specify): ☐ Serving criminal sentence ☐ Awaiting sentencing ☐ Under protective custody ☐
Date of incarceration:

☐ Other please specify location of contact:

THE INDIVIDUAL IS: ☐ **AT RISK TO SELF** ☐ **AT RISK TO OTHERS**

BECAUSE OF THESE SYMPTOMS & BEHAVIORS

☐ Agitated/Aggressive	☐ Florid Mania	☐ Suicidal -Means/Plan/Intent
☐ Delusions	☐ Hallucinations	☐ Other (please specify):
☐ Disoriented	☐ Homicidal	

OTHER FACTORS: ☐ Domestic Violence ☐ Homeless ☐ Under the influence of alcohol / drugs.
Suspected substance(s): Drug of Choice: Date of Last Use:

PRESENTING ISSUE

☐ Mental Health Issue ☐ Substance Abuse ☐ Co-occurring

Mental Health Practitioner Signature: _____

THIS FORM MUST BE SUBMITTED WITHIN 45 DAYS OF DATE OF SERVICE FOR CIR SERVICES
This form cannot be processed if the information submitted is illegible or incomplete. June 2018

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RECOMMENDATIONS / CRISIS PLAN	
Strengths/Resources/Natural Supports:	

DISCHARGE INFORMATION			
Was this individual the client of a mental health service provider or agency at the time of this crisis? ☐ Yes ☐ No			
Discharge To:	**Date of appointment:**		
☐ Client refused referrals:	Prescriptions given at discharge: ☐ Yes ☐ No	☐ Client refused medication:	
Written information provided to (please specify information given and to whom):			
☐ Client:	☐ Family/friend:		
☐ Community Supports (i.e., 12 step, religious/spiritual):			
☐ Other (i.e., MD, MHC, OPT, Detention Officer, etc.):			
DISCHARGED TO:			
☐ Acute Inpatient Psychiatric Unit	☐ Home	☐ Homeless Shelter	☐ Other (please specify):
☐ Crisis Stabilization Program	☐ Family / friend	☐ Montana State Hospital	
☐ Client left crisis stabilization services against medical advice.			

CIR SERVICES	Agency/Facility/Detention Name:	
DATE & Time In-Time Out:	**CIR Code**	**Documentation must support billing code.**

Crisis Care Manager Signature:_____ **Date:**

Print Form Save Form Reset Form

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