



# PINELLAS COUNTY HEALTH PLAN

## Behavioral Health Referral

Fax completed referral to: Pinellas County Health and Human Services at (727) 464-8428 Attn: Lynn Speiser  
**INCOMPLETE REFERRALS WILL BE RETURNED TO YOUR OFFICE**

Client Name	Date
SS#	Referring Prescriber
Date of Birth	Prescriber Phone
Client phone/contact number	Ever hospitalized for this concern?

### What medication is client currently on to manage this problem?

*ATTENTION MENTAL HEALTH and/or SUBSTANCE ABUSE TREATMENT FACILITY*  
*This client is being referred to your mental health/substance abuse facility in accordance with contractual obligations of the RFP 067-0075 for Mental Health/Substance Abuse program.*  
**\*\*\*\*\*It is the responsibility of the Mental Health/Substance Abuse facility to contact the client and/or physician to advise of all appointments.**  
**\*\* Obligations are outlined in the Final Agreement between the Department of Health and Human Services and the facilities involved in this contract.**

### DAST 10 DRUG ABUSE SCREENING TEST

These questions refer to the past 12 months		<u>PLEASE CIRCLE YOUR RESPONSE</u>	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your use of drugs?	Yes	No
7.	Have you neglected your family because of your drug use?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. Memory loss, hepatitis, convulsions, bleeding)?	Yes	No

### PHQ-9 PATIENT HEALTH QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems?		<u>PLEASE CIRCLE YOUR RESPONSE</u>			
		Not at all	Several days	More than half the time	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or over eating	0	1	2	3
6.	Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot	0	1	2	3
9.	Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add columns					
		Total:			
10	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? <u>PLEASE CIRCLE YOUR RESPONSE</u>				
Not difficult at all		Somewhat difficult		Very Difficult	
				Extremely difficult	

### CAGE ALCOHOL SCREENING TEST

PLEASE CIRCLE YOUR RESPONSE			
1.	Have you ever felt you should Cut down on your drinking?	Yes	No
2.	Have people Annoyed you by criticizing your drinking?	Yes	No
3.	Have you ever felt bad or Guilty about your drinking?	Yes	No
4.	Have you had an Eye opener first thing in the morning to steady nerves or get rid of a hangover?	Yes	No

Over the last 2 weeks, how often have you been bothered by any of the following problems? PLEASE CIRCLE YOUR RESPONSE		Not at all	Several days	Half the time	Almost Always
1.	Feeling nervous, anxious, or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble sleeping	0	1	2	3
5.	Being so restless that it's hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3
Add Columns:					
		Total			
8	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? PLEASE CIRCLE YOUR RESPONSE				
Not difficult at all		Somewhat difficult		Very Difficult	
				Extremely Difficult	

\*\*\*\*\*SCORING TO BE DONE BY PROVIDER OR DESIGNEE\*\*\*\*\*PLEASE CIRCLE RESPONSE

DAST 10  
Each Yes response=1

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No Problems Reported	None at this time
1 - 2	Low Level	Monitor, Reassess at a later date
3 - 5	Moderate Level	Further investigation
6 - 8	Substantial Level	Intensive Assessment

CAGE 4

# OF YES RESPONSES. Two "yes" responses indicate that the respondent should be investigated further

PHQ-9

Score	Depression Severity	Action
0 - 4	None	The patient may not need depression treatment
5 - 9	Mild depression	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
10 - 14	Moderate depression	
15 - 19	Moderately severe depression	Warrants treatment for depression, using anti-depressant, psychotherapy and/or a combination of treatment
20 - 27	Severe depression	

GAD-7

Score	Level of Anxiety	Score	Level of Anxiety	Score	Level of Anxiety
<5	Mild	6 - 14	Moderate	> 15	Severe

\_\_\_\_\_  
SIGNATURE OF HEALTH CARE PROFESSIONAL

\_\_\_\_\_  
DATE

To Be Completed by Pinellas County Health and Human Services

Referred to:

- Boley Centers, Inc.       Directions for Mental Health  
 Operation PAR, Inc.       PEMHS       Suncoast Center