## **Date** **Time** **PART A Completed By:**

Caller Name/Title: Phone #

Company: Address:

City: County: Zip Code:

Patient Referred By: Primary MD Tel #

Patient Resides at: SNF ☐ Home ☐ Group Home ☐ Assisted Living ☐ Other ☐

## **PART A: PATIENT INFORMATION**

zxcv989

Patient Name: Age: DOB:

Male: Female: Address:

City: County: Zip Code:

#:

#:

Insurance: Primary: Secondary:

Phone:

Name:

SSN # DPOA/Guardian/

Family

Three (3) questions to establish capacity to consent for admission as a voluntary patient when appropriate

Who are you?☐ Where are you?☐ Why are you here?☐

|  |
| --- |
| Date/Time |

**PART B: PRE-ADMISSION SCREENING** **PART B & C Completed By:**

REASON FOR REFERRAL:

ADMISSION CRITERIA: *Check all that apply*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Suicidal Ideation/plan/attempt |  | Acute severe exacerbation of chronic symptoms |
|  | Requires intensive follow-up |  | Assaultive destructive behavior/assaultive/poor impulse control |
|  | Risk due to disorientation/impairment |  | Medication withdrawal change toxic effects or non-compliance |
|  | Failed less intensive level of care |  | Psychiatric symptoms severe causing bizarre disordered behavior |
|  | Sleep/nutrition disturbance poses risk |  | Other: *Describe:* |

Current Medical Condition(s):

Medically Cleared by:

Medications (Include Non-Prescription):

**PART C: DISPOSITION AND STATUS**Date: Time:

Please check the box(s) that apply

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | General information only |  | Ref. source chose another facility |  | Administrative denial |
|  | Clinical admission criteria not met |  | Failed to keep appointment |  | At baseline functioning |
|  | Medically unstable |  | Non-participating PPO/HMO |  | Physician declined to admit |
|  | Pt/family refused |  | Unable to follow up |  | Age inappropriate |
|  | Pt/family chose another facility |  | No space available: *current census #* |  | Not appropriate for milieu |
|  | Census cap staffing |  | Census cap/environment |  | Census cap/other |

Referral Instructions:

Admission Date: Time: Voluntary: Involuntary:

Authorizing Physician: Time Attending Physician:

Review Date: Time: PD Signature: