Reset Form

DIVISION OF MENTAL HEALTH AND ADDICTION (DMHA) HOSPITAL REFERRAL

State Form 52179 (R2 / 3-13)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

Date of referral *(month, day, year)*
Update *(month, day, year)*

Mark all State Operated Facilities (SOFs) receiving: ☐ EPCC ☐ ESH ☐ MSH ☐ LCH ☐ RSH ☐ LSH

Preference: ☐ EPCC ☐ ESH ☐ MSH ☐ LCH ☐ RSH ☐ LSH

Primary Diagnosis/Population Type:
☐ SMI ☐ MICA ☐ SED ☐ Forensic ☐ Research

Secondary Diagnosis:
☐ MRDD

Bed type requested:
☐ Allocated ☐ Unallocated

Referral Source to Gatekeeper:

☐ Self, family, or friend
☐ Human Services Agency
☐ Health/Rehab Clinic (other)
☐ CMHC
☐ Non-Health Care Facility
☐ Justice System
☐ Acute Care Hospital (other inpatient or ER)
☐ Internal Inpatient Transfer
☐ Skilled Nursing or Intermediate Care Facility
☐ Information Unavailable
☐ Other clinic (PIP or rural health)

PATIENT INFORMATION

Name of patient *(last, first, middle, maiden)*	Date of birth *(month, day, year)*	Social Security number	Sex ☐ Male ☐ Female
Home address *(number and street)*	Telephone number	Primary language	Race
City	County	Previous SOFs:	

MARITAL STATUS:
☐ Married
☐ Divorced
☐ Single
☐ Widowed

COMMITMENT STATUS:
☐ Temporary Commitment ☐ ICST
☐ Extended Temporary ☐ Commitment Pending
☐ Regular Commitment ☐ Voluntary

Date of Commitment: _____
County of Commitment: _____
Order to Treat: _____

Any outstanding legal charges? ☐ Yes ☐ No
Forcible Felonies? ☐ Yes ☐ No
County: _____
Explain: _____

LOC for MR/DD: ☐ Yes ☐ No
Expiration date *(month, day, year)*: _____

Check if:
☐ Health Care Representative ☐ Custodial Parent
☐ Legal Guardian

Emergency contact:
☐ Same as above ☐ Different ☐ Release attached

Name	Relationship
Address *(number and street, city, state, and ZIP code)*	Telephone number
Name	Relationship
Address *(number and street, city, state, and ZIP code)*	Telephone number

Insurance: **Numbers:**
☐ Medicare _____
☐ Medicaid _____
☐ Other _____

Financial Resources:
☐ SSD $_____
☐ SSI $_____
☐ VA $_____
☐ Other $_____

Payee:
☐ Self
☐ Other

Name of payee

Address *(number and street, city, state, and ZIP code)*

PSYCHIATRIC INFORMATION

Current placement	Date admitted *(month, day, year)*
Address *(number and street, city, state, and ZIP code)*	
Diagnosis Axis I Axis II Axis III	GAF: Past 12 months GAF: Current IQ (MR/DD):

Current Symptoms and Behaviors :

Reason for Hospitalization

RECOVERY NEED

Select 2:
1 = Primary Treatment Need
2 = Secondary Treatment Need

___ Stabilization of Psychiatric Symptoms
___ Reduction of Aggressive Behavior
___ Improved Medication Management
___ Improved Treatment Plan Participation
___ Community Integration Training
___ Specialized Treatment Programming
___ Completion of Substance Abuse Program
___ Reduction of Inappropriate Sexual Behaviors
___ School or Educational Programming
___ Increased Diagnosis Awareness
___ Demonstration of Behavior Mod Skills
___ Increased ADL Proficiency
___ Stabilization of Medical or Nursing Issues
___ Reduction of Self Harming Behavior
___ Legal Education
___ Restoration of Competency
___ Other: _____

COMMUNITY INTEGRATION TRAINING MODULES
Defined From "Recovery Need"

Select 2

☐ Socialization Skills
☐ Coping Skills
☐ Stress Identification
☐ Problem Solving Skills
☐ Communication Skills
☐ Health Education & Awareness
☐ Nutritional Education
☐ Money Management
☐ Vocational Preparation
☐ Resource Linkage
☐ Support System Development
☐ Other: _____

SPECIALIZED TREATMENT PROGRAMMING
Defined From "Recovery Need"

Select 1 (1 from Each Subcategory)

☐ MI + Addiction Treatment
☐ Sexual Responsibility Training
☐ Borderline Treatment Program
☐ Polydipsia &/or Fluid Management
☐ MI + MRDD
☐ Eating Disorder
☐ PTSD – Combat Related
☐ Impairment *(Select 1)*
  ☐ Physical Disability
  ☐ Visual
  ☐ Deaf
  ☐ Mobility
  _____
  ☐ Adaptive Equipment Needs
☐ Overt Aggression *(Select 1)*
  ☐ Verbal
  ☐ Physical - Objects
  ☐ Physical - Self
  ☐ Physical - Others
☐ Other: _____

Specify measurable recovery goals related to the treatment needs noted above:
Goal for primary treatment need:
Goal for secondary treatment need:

ANTICIPATED LENGTH OF STAY AND PLACEMENT AVAILABILITY UPON DISCHARGE

	Exists	Development Required	Full with Wait List	Exists Out of Home Area	Does not Exist without Modification
1 - 6 months	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
6 – 12 months	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15
1 – 2 years	☐ 16	☐ 17	☐ 18	☐ 19	☐ 20
2 – 3 years	☐ 21	☐ 22	☐ 23	☐ 24	☐ 25

Has the Patient Experienced or Demonstrated *(Check all that apply)*:

☐ Violence to self within last six (6) months
Last date *(month, day, year)*: _____
Specify: _____

☐ Violence to others within last six (6) months
Last date *(month, day, year)*: _____
Specify: _____

☐ Substance abuse within last six (6) months
Last date *(month, day, year)*: _____
Substance type: _____

☐ Psychological Trauma (at any time – includes physical, sexual, emotional abuse and/or severe childhood neglect):
Substance type: _____

☐ History or Current Suicidal Ideation

Current Medications and Dosages:	Medications Recently Changed and Reason:

TREATING PHYSICIAN

Name of physician	Telephone number

MEDICAL NEEDS / SPECIAL NEEDS

☐ Diet
Specify: _____
_____

☐ Mobility
Restrictions:_____
_____
Assistive Devices:_____
_____

☐ Fall Risk
☐ Low ☐ Moderate ☐ High

☐ Hearing Impairment
☐ Mild ☐ Moderate ☐ Severe
Assistive Devices:_____
_____

☐ Visual Impairment
☐ Mild ☐ Moderate ☐ Severe
Assistive Devices:_____
_____

☐ Other Medical Equipment
Specify: _____
_____

☐ Communication Difficulty
Assistive Devices:_____
_____

☐ Past History of T.B.
Current PPD:
Results: _____
Date: _____
Chest X-Ray:
Results: _____
Date: _____

☐ Communicable Disease
Specify: _____

☐ Communicable &/or Infectious Disease History
☐ History of MRSA
☐ History of Multi-drug
☐ Resistant Organisms.

☐ Diabetes
☐ Insulin Dependent

☐ Allergies
List:_____
_____
_____

☐ Surgeries Within the Last 12 Months
Specify: _____
_____

☐ Circulatory Issues (Heart Disease, HTN, etc.)
Specify: _____

☐ Respiratory (COPD, asthma)
Specify: _____
Assistive Devices:_____

☐ GI Tract (ulcers, gastric reflux, colostomy G-tube, etc.)
Specify: _____

☐ GU Tract - Urinary (dialysis, incontinence, catheter, etc.)

☐ Polydipsia

☐ Integumentary System (Skin Issues)
Specify: _____

☐ Neurological (seizures, NMS, altered gait)
Specify: _____

Smoking History

☐ Currently smokes: amt/day _____
☐ Quit smoking less than 1 year ago
☐ Never smoked
Received counseling for smoking:
☐ Yes Approx date: _____
☐ No
☐ Currently uses other tobacco products
Type: _____

Provide additional information regarding the current treatment of items specified in Medical/Special Needs section (as applicable).
A copy of current physical may be used if current treatment is included. Attach additional sheets if necessary.

ANSA/CANS Completion Date *(month, day, year)*: _____ LON: _____

Patient strengths:

a) _____

b) _____

c) _____

GATEKEEPER / DISCHARGE PLAN - Community Placement Needs

Name of agency

Gatekeeping Liaison Coordinating Admission/Discharge	Telephone number
Address *(number and street)*	Date *(month, day, year)*
City / State / ZIP code	Signature

☐ SGL (24hr) SMI	☐ DOC (forensic only)
☐ SGL (24hr) MR/DD	☐ Subacute
☐ MRDD Supported Living Waiver	☐ MRDD ESN
☐ MRDD ICF/MR Facility	☐ Children's Residential Facility
☐ Family Personal Home	☐ Halfway Program – Chemical Addiction
☐ Specialized Residential Facility	☐ AFA
☐ Medical or Nursing Facility	☐ Therapeutic Foster Care
☐ Cluster Apt. Setting or SILP	☐ Other: _____

GATEKEEPER / DISCHARGE PLAN - Post SOF Community Program Needs

☐ AIRS / CAIRS	☐ SOC – Systems of Care (SED)
☐ Intensive Outpatient	☐ Children's Medicaid Waiver
☐ Medication Evaluation & Monitoring	☐ Behavioral Modification & Support
☐ Case Management	☐ Community Habilitation
☐ Substance Abuse Aftercare	☐ Health Care Coordination
☐ Vocational & Employment Services	☐ Prevocational/Sheltered Employment
☐ ACT – Assertive Community Treatment	☐ Supportive/Supported Housing
☐ IDDT – Integrated Dual Diagnosis Treatment	☐ IMR – Illness Management and Recovery Program
☐ ATR – Access to Recovery	☐ Other: _____

Required Signatures: ***Consumer:***	Date *(month, day, year)*
_____ Consumer Signature &/or Parent or Guardian	_____
_____ Witness if No Consumer Signature	_____
Gatekeeping Staff Completing Referral on Behalf of Agency:	
_____ Staff Signature	_____
_____ Title / Agency &/or Unit	
_____ Telephone number	

DMHA HOSPITAL REFERRAL FORM DIRECTIONS

When referral to a DMHA hospital is determined appropriate by the Gatekeeper, the DMHA Hospital Referral Form is to be completed, signed by the Gatekeeper and forwarded to the appropriate hospital with the supporting documents listed below. Upon receipt of the form and required documents, the hospital admissions team will review and contact the Gatekeeper within five working days regarding service appropriateness, bed availability, and waiting list.

The following documents are required with the Admission Referral Form:

- Current mental status (most recent psychiatric assessment) and significant findings
- Current risk factors (self-harm, aggression, elopement, falls, etc.)
- Current full physical examination within 30 days of admission
- Any pertinent medical workups including labs within 30 days of referral
- Commitment papers (or as soon as available; must be prior to admission)
- Legal papers (guardianship, wardship, Advance directives, DNR's, 4CR designations, probation contacts/status, status of legal charges, etc.)
- Current treatment plan (include current medications with dosages)
- Current psychological testing scores if available
- Identification Verification (state issued picture IDs, drivers license (if applicable), birth certificate, etc.)
- All available financial information (Medicaid/Medicare cards, SS cards, income verification, etc)
- Result of TB test (date given and read). Test given within 30 days of referral but required within 90 days prior to admission.
- ANSA/CANS (within 30 days of referral and updated every 90 days if waiting)

Additional documentation is required for referrals with secondary MR/DD diagnosis and Child/Youth referrals:

<u>Referrals with Secondary MR/DD:</u>

- Diagnostic and Evaluation
- DD Eligibility if Determined (LOC)
- Summary of BDDS Involvement
- CMHC Screening
- School History and Education (IEP if available)
- Psychological testing scores and clinical contact information
- Summary of Supports Provided by MR/DD provider &/or CMHC

<u>Child/Youth Referrals</u>

- Immunization records
- School History & Education, Records & IEP (psychoeducational evaluation, if possible)
- History of Past Treatment
- Birth Certificate

An updated Admission Referral Form must be submitted for a consumer exceeding **30 days** on the admissions wait list. ~~.~~ Updates must be submitted by using designated Attachments A or B. A discharge summary from the current placement must be submitted with the final update. This is to insure that the state hospitals have current information at admission. Initial referral and referral updates must be discussed and signed by the consumer &/or legal guardian. A witness must sign for those without legal guardians and/or those refusing to sign.

Upon admission a written update is required designating behavioral status. A medication reconciliation sheet must be attached identifying medications given in the last 24-hours, time of next dosage, and a contact number if SOF needs clarification or further details.

Reference: 1) DMHA Assessment Requirements for Children and Adults Entering All State Owned or Operated Mental Health Institutions
2) Definitions of Referral Source to Gatekeeper

DEFINITIONS OF REFERRAL SOURCE TO GATEKEEPER

IMPORTANT: This field identifies who referred the patient to the community mental health center (CMHC):

(01) Self, family or friend

- Client came directly to the CMHC from home, family, streets, etc.

(02) Community Mental Health Center / Managed Care Provider

- Client was already the CMHC's patient; or in a group home, halfway house, supervised apartments
- Client was referred to the gatekeeper by another CMHC/MCP

(03) Acute Care Hospital

- Any inpatient unit other than the CMHC or subcontracted facility or ER

(04) Internal Inpatient Transfer

- Transfer from a hospital inpatient unit at the same facility resulting in a separate claim to the payer source

(05) Human Services Agency

- Referral from a social service agency such as shelters, food pantry, and/or non-mental health related “help” organization

(06) Non-Health Care Facility

- Residential service provider not associated with the CMHC
- Outpatient service provider not associated with the CMHC

(07) Skilled Nursing or Intermediate Care Facility

- Nursing homes and/or rehabilitation centers

(08) Health/Rehab Clinic

- Inpatient rehabilitation unit for medical issues and/or critical access hospitals
- Assisted living programs

(09) Justice System – Jail, Correctional Facility, Correction-Related Agencies

- Office of General Counsel (DMHA legal office) referrals made to SOF’s
- Client was referred to the CMHC by police, court, correction/probation agencies, juvenile justice, probate court, civil court, others.

(10) Information Unavailable

- Origin of client’s referral to the CMHC is unavailable or unknown.
- Written or verbal history is unable to be verified or determined.

(11) Other Clinic

- A free-standing psychiatric provider
- Rural health care clinics