Facility Medical Record #: _____ Admitting State Hospital: _____
Last 4 of SSN: _____ Date: _____ Time: _____

NC DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES
Regional Referral Form for Admission to a State Psychiatric Hospitals

Referral by: ☐ Hospital ED ☐ Hospital Unit ☐ Walk-In ☐ LME/MCO ☐ Tailored Plan ☐ Standard Plan ☐ Community Providers ☐ Other: _____

Type of Admission: ☐ Voluntary ☐ Involuntary ☐ MH ☐ MH/SA ☐ Incapable to Proceed (ITP) ☐ Not Guilty by Reason of Insanity (NGRI)

Unit Requested: ☐ Adolescent ☐ Adult ☐ Child ☐ Geriatric ☐ Deaf ☐ Forensic Maximum (FMAX) ☐ Forensic Minimum (FMIN) ☐ Medical.

Name of Referral Source/Agency: _____ Contact #: _____

Name: _____ Date of Birth: _____
Last First Middle Maiden MM/DD/YYYY

Other Names Used (if applicable): _____ Gender: ☐ Male ☐ Female ☐ Non-binary Ethnicity: _____

Minor? ☐ Yes ☐ No Incompetent Adult? ☐ Yes ☐ No

Legal Guardian/Parent Name: _____ Relationship of Guardian to Individual: _____
NOTE: IF AVAILABLE, GUARDIANSHIP PAPERS MUST BE SUBMITTED WITH REFERRAL. IF NOT, MUST OBTAIN AND SUBMIT ASAP.

Parent/Guardian Address: _____ Phone: _____

County of Residence: _____ Additional Contact Numbers (if applicable): _____

Preferred Language: _____ Read/Write English: ☐ Yes ☐ No Is an interpreter needed? ☐ Yes ☐ No

☐ Deaf or Hard of Hearing and uses American Sign Language as primary means of communication.

Current risk: ☐ Suicidal ☐ Homicidal Describe (attempts, thoughts, plans): _____

Has individual previously been admitted to any state facility? ☐ Yes ☐ No

_____

_____

_____

Mental Status (appearance/affect/behavior/hallucinations): _____

_____

_____

_____

Primary Diagnosis (for UM): _____ Secondary Diagnosis: _____ Tertiary Diagnosis: _____

Medical Diagnosis(es): _____

_____

_____

Follow SB859 (1997) procedures for IDD referrals. Does individual meet IDD exception criteria as identified in 122C-261 (f), 122C-262 (d), 122C-263 (d) (2) regulations? ☐ Yes ☐ No If IDD, has NC START Referral been made? ☐ Yes ☐ No

Assessment of Functioning Measures: _____

IQ Available: ☐ Yes ☐ No If Yes, Score: _____ Test: _____ If yes, when available, attach documentation.

Psychosocial Stressors: _____

_____

_____

Other Treatment Used Prior to Referral to Hospital: _____

_____

_____

Reason(s) that Other Treatment Efforts were not Successful: _____

_____

_____

Previous Medical/Psychiatric/SA Admission(s) or denials to any Hospital/Facility in the past 3 months (where, when why?) _____

_____

_____

Medical History: ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Seizure Disorder ☐ Asthma ☐ Ambulatory
☐ Hepatitis ☐ Chronic Pain ☐ Recent Trauma ☐ Recent Seizure ☐ TBI ☐ Other: _____

Comments: _____

Is the consumer/patient pregnant: ☐ Yes, how many weeks: _____ ☐ No ☐ Unknown If yes, include ALL prenatal care information.

Name: _____

Current Medications			
Name	**Date of Last Dosage**	**Name**	**Date of Last Dosage**

Side Effects to Medications: _____

_____

History of Compliance with Medications: _____

_____

Allergies: _____

Time Vital Signs Taken: _____ BP: _____ Pulse: _____ Resp: _____ Temp: _____ Weight: _____

BAC: _____ Time: _____

Labs Available: ☐ Yes ☐ No If Yes, attach a copy of the labs. If not, obtain and submit ASAP take verbal report on labs until you may secure lab record.

Pending/Current Legal Charges: ☐ Yes ☐ No ☐ Unknown ☐ Detainer (County: _____) Court Order: ☐ Yes ☐ No

Description: _____

_____

☐ House Bill 95 (ITP) ☐ Senate Bill 43 (NGRI) Capacity Restoration: ☐ Yes ☐ No If Yes, when available, attach copy of documentation.

Goal of SPH inpatient: _____

_____

Treatment Objectives (Including specific suggestions for treatment planning): _____

_____

_____

Proposed Discharge Plans: _____

_____

_____

Placement Considerations: _____

_____

_____

Identified Additional Social Supports/Resources:

Name:	Address:	Phone #:	Relationship:

Additional Contact Information:

TP/SP Provider Agency: _____ Phone: _____ Fax: _____

Agency After Hours/On-Call: _____ Phone: _____ Fax: _____

TP Care Manager: _____ Phone: _____ Fax: _____

ACT/Community Support Team Provider: _____ Phone: _____ Fax: _____

LME/MCO Contact: _____ Phone: _____ Fax: _____
(Hospital Liaison/Care Coordinator/TCL In-Reach, Transition Coordinator/Other LME Representative)

NC Start Case Manager: _____ Phone: _____ Fax: _____

Assigned Psychiatrist: _____ Phone: _____ Fax: _____

Other Provider: _____ Phone: _____ Fax: _____

Insurance:

Third Party Coverage: Medicaid #: _____ Medicare #: _____ Other: _____

Responsible County (LME/MCO Home County): _____ Phone: _____ Referring County (LME/MCO Host County): _____ Phone: _____

Insurance Company: _____ Policy Holder: _____ Policy Number: _____

Attach copy of insurance card if available If Insurance, Hospitals contacts: _____

Form completed by: _____
Signature Title Date