# Facility Medical Record #: Admitting State Hospital/ADATC:

**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 Hospital or ADATC**

# Referral to:

**Regional Psychiatric Hospital**

**ADATC**

**Referral made by:**

**Provider**

**LME/MCO**

**Self-Referral**

**ED/Hospital**

**Other:**

**Name of Referral Source/Agency: Contact #:( )**

Consumer/Patient’s Name: Date of Birth:

Last First Middle/Maiden MM DD YY

Other Names Used by Consumer (if applicable):

Gender:

Male

Female

Legal Guardian/Parent Name: Relationship of Guardian to Consumer:

Consumer/Parent/Guardian Address: Phone :( )

Consumer’s Ethnicity: Consumer’s Contact Number(s): Home :( ) Work :( )

Consumer’s County of Residence:

# Sign Language as primary means of communication

Type of Admission: Is Consumer Currently:

# Consumer is Deaf or Hard of Hearing and uses American

Suicidal Homicidal

Voluntary MI SA Describe (attempts, thoughts, plans):

Involuntary MI/SA

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

Current Withdrawal Symptoms:

**SUBSTANCE USE INFORMATION: PLEASE COMPLETE FOR ALL INDIVIDUALS SUSPECTED OF SA USAGE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug of Choice Priority #** | **Major Substances Used** | **Route \*** | **Frequency\*\*** | **Date Last Used** | **Average Amount Used** |
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\***Route Codes:** 1=Oral 2=Smoking 3=Inhalation 4=Injection 5=Other 9=Unknown

\*\***Frequency Codes:** 0=Drug not used during past month 3=Drug used 3-6 times per week 1=Drug used 1-3 times in past month 4=Drug used daily

2=Drug used 1-2 times in past week

# ASAM CRITERIA (3rd EDITION): FOR USE WITH ADATC REFERRALS

**Please select the appropriate level:**

**Level 1** – Outpatient Services

**Level 2.1** – Intensive Outpatient Services

**Level 2.5** – Partial Hospitalization Services

**Level 3.1** – Clinically Managed, Low-Intensity Residential Services

**Level 3.3** – Clinically Managed Population-Specific, High-Intensity Residential Services **Level 3.5** – Clinically Managed High-Intensity Residential Services (Adult Criteria) **Level 3.7** – Medically Monitored Intensive Inpatient Services (Adult Criteria)

**Level 3.9** – Medically Monitored/Managed Intensive Inpatient Services

**Level 4.0** – Medically Managed Intensive Inpatient Services

**\*\* Lack of availability of appropriate, criteria-selected care and/or poor outcomes at a given level of care warrant a reassessment of the treatment plan with a view to modify the treatment approach.**

# CONSUMER’S/PATIENT’S NAME:

**FEMALE ADATC REFERRAL: *CHECK ALL THAT APPLY***

Individual is pregnant: Yes, # weeks No Unknown **If yes, include ALL prenatal care information**



Individual has child(ren): Yes No If yes, Age(s) Individual has custody of child(ren): Yes No If no, who has custody:



**FEMALE WBJ-ADATC REFERRAL: *CHECK ALL THAT APPLY***



Child under 1 year of age will accompany individual to WBJ **If yes, include ALL of child’s medical record**

Involvement by Department of Social Services: Yes No

# If yes, include DSS contact information (DSS caseworker name, agency name and phone number)

**COMPLETE FOR ALL CONSUMERS/PATIENTS:**

Principal Diagnosis:

Behavioral Health Diagnoses: ***Follow SB859 procedures for MR/DD referrals*** Medical Diagnoses: Psychosocial Stressors: Assessment of Functioning Measures:

PCP Available:

Yes

## No If Yes, Please Attach If PCP is not available attach current treatment plan and/or crisis plan

Previous Medical/Psychiatric/SA Admission(s) to Any Hospital/Facility in the past 3 months (where, when, why):

Other Treatment Used Prior to Referral to Hospital:

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

Medical History:

Heart Disease

Hypertension

Diabetes

Seizure Disorder

Pregnant

Ambulatory

Hepatitis

Chronic Pain

Recent Trauma

Recent Seizure

Asthma

Other

Comments:

**Current Psychiatric Medications/Injections**: **Current Medical Medications/Injections:**

Date of Last Dosage:

Date of Last Dosage:

Date of Last Dosage:

Date of Last Dosage:

Date of Last Dosage:

Date of Last Dosage:

Date of Last Dosage:

Date of Last Dosage:

Date of Last Dosage:

Date of Last Dosage:

Date of Last Dosage:

Date of Last Dosage:

Side Effects to Medications: Allergies: History of Compliance with Medications: Time Vital Signs Taken: BP: Pulse: Resp: Temp: Weight: BAC: Time:

Labs Completed:

## Fax applicable lab work along with referral form

Pending Legal Charges:

Yes No

Detainer (County) Court Order

Yes No

Unknown Description: Court Order Attached House Bill 95 (ITP) Senate Bill 43 (NGRI)

Consumer Adjudicated Incompetent: Yes No ***If yes, attach copy of documentation if available***

Is Consumer a Minor?

Yes

No Name of Responsible Parent/Adult/Guardian:

# CONSUMER’S/PATIENT’S NAME:

Goal of Hospitalization: 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**:  Clinical Home Provider Agency: Phone: ( | ) Fax: ( | ) |
| Agency After Hours : Phone: ( | ) Fax: ( | ) |
| LME/MCO Contact: Phone: ( | ) Fax: ( | ) |
| (*Hospital Liaison/Care Coordinator/Other LME Representative*)  Assigned Psychiatrist: Phone: ( | ) Fax: ( | ) |
| Community Support Team Provider: Phone: ( | ) Fax: ( | ) |
| Other Provider: Phone: ( | ) Fax: ( | ) |

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

Insurance Co.:

Policy Holder:

Policy Number:

***Attach copy of insurance card if available* If Insurance: Hospitals Contacted:**

**1)**

Form completed by:

**2)**

Signature **3)**

Title Date

|  |
| --- |
| **Hospital Beds ADATC Beds**  Adult Admissions Crisis  Adults Long-Term Detox  Geriatric Admissions Inpatient Rehab  Adolescent Admissions  Child Admissions |

# SERVICE REQUESTED:

# LME/MCO TO COMPLETE ONLY FOR REFERRAL OF LME/MCO MEMBERS TO ADATC (PHPs DO NOT COMPLETE)

|  |  |
| --- | --- |
| ***Referring* County: Phone #: Authorization #**: From: To\*:  \*Day not covered | ***Responsible* County: Phone #: Authorization #**: From: To\*:  \*Day not covered |

**FOR ADATC USE ONLY – IF NO AUTHORIZATION INFORMATION IS PROVIDED BY THE LME:**

|  |  |
| --- | --- |
| ***Referring* County: Phone #: ADATC Staff Making Phone Call:**  No Response Within 1 Hour of Call  If Response – Person Authorizing Days: | ***Responsible* County: Phone #: ADATC Staff Making Phone Call:**  No Response Within 1 Hour of Call  If Response – Person Authorizing Days: |

**PLEASE NOTE:**

**ANY MISSING INFORMATION MUST BE SENT TO THE ADMITTING FACILITY WITHIN ONE WORKING DAY OF THE CONSUMER’S ADMISSION. GUARDIANSHIP PAPERS MUST BE FORWARDED WITHIN ONE WORKING DAY OF ADMISSION.**