**Department of Health & Human Services**

**Division of State Operated Healthcare Facilities**

**Neuro-Medical Treatment Centers (NTCs)**

**Referral for Admission**

Individual or Legally Responsible Person has provided consent for referral to the following Neuro-Medical Treatment Center(s): *Referral Consent form NTC-3103 must accompany referral.*

**Black Mountain NTC**  **Longleaf NTC**  **O’Berry NTC**

Black Mountain, NC Wilson, NC Goldsboro, NC **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referring Agency:** |  | **Date of Referral:** |  |
| **Referral Contact:** |  | Telephone: |  |
|  |  | Email Address: |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION I: APPLICANT INFORMATION** | | | | | | | | | | | | | |
| **Name:** |  | | | | | **Preferred Name:** | | | |  | | | |
| **Date of Birth:** | |  | | **Gender:** | | |  | | | Race/Ethnicity: | | |  |
| Country of Birth: | |  | | Citizenship Status: | | |  | | | Primary Language: | | |  |
| Marital Status: Never Married  Married  Widowed  Separated  Divorced | | | | | | | | | | | Maiden Name: |  | |
| **Home Address:** | | |  | | | | | | **County:** | | | |  |
| SSN: | | |  | | Medicare # | | |  | | | | | |
| Medicaid # | | |  | | Other Insurance: | | |  | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Location:** |  | **Date of Admission:** | |  |
| Facility Type: |  |  |  | |
| Address: |  | Phone: |  | |
| Reason for Admission: |  | | | |

**SECTION II: SYSTEM OF SUPPORT CONTACTS**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Has the applicant been adjudicated incompetent? | | | | YES  NO | | | | | | |
| **If YES, Type of Guardianship:** | | Guardian of Person  Guardian of Estate  General Guardian | | | | | | | | |
|  | | County Adjudicated: | | | |  | | Date of Adjudication: | |  |
| **Legally Responsible Person/Agency:** | |  | | | | | | | | |
| Address: |  | | | | | | | | | |
| Phone: |  | | Alt Phone: | |  | | E-Mail: | |  | |

**Additional Supports:**

|  |  |
| --- | --- |
| Support Person: | Relationship to Applicant: |
| Address: | Phone/email: |
| Support Person: | Relationship to Applicant: |
| Address: | Phone/email: |

**Comments on support network:**

**SECTION III: MEDICAL INFORMATION**

**Active Diagnoses**

|  |  |
| --- | --- |
| Medical: |  |
| Psychiatric: |  |

**Recent Hospitalizations/Surgeries/Serious Illnesses or Injuries**

|  |  |  |
| --- | --- | --- |
| **Year** | **Hospitalization/Surgery/Illness or Injury** | **Description/Treatment** |
|  |  |  |
|  |  |  |
|  |  |  |

**Other Health Information**

**Allergies**

|  |  |
| --- | --- |
| Allergen (e.g., medication, food, latex, gelatin, bee stings, etc.) | Type of Reaction (e.g., rash; hives; serious life-threatening reaction requiring emergency treatment; etc.) |
|  |  |
|  |  |
|  |  |

**Seizures**

|  |  |  |  |
| --- | --- | --- | --- |
| Type(s)/Description |  | | |
| Frequency/Duration |  | Date of last seizure |  |

**Diet/Nutrition**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Height** |  | **Weight** |  | | | |
| **Dysphasia** | Yes  No | **Swallowing Study** | | Yes  No | Date: |  |
|  |  | Results: | |  | | |
| **Diet:** | Regular  Chopped  Pureed  Liquid  Feeding Tube | | | | | |
| Feeds Self: | Yes  No | Adaptive Equipment Used: | | Yes  No Type: | | |

**Hearing/Speech/Vision**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hearing** | Normal  Mild-Mod Impairment  Severe Impairment | **Hearing Aid** | Yes  No |
| **Speech** | Clear  Slurred or Mumbled  Absent or Unintelligible | | |
| **Vision** | Normal  Mild-Mod Impairment  Legally Blind | **Glasses** | Yes  No |

**SECTION IV: COGNITIVE AND FUNCTIONAL STATUS**

Intellectual/Developmental Disability:  Yes  No Diagnosis:

Level of ID:  Mild  Moderate  Severe  Profound  Unknown

**Self-Care Skills:**

For each item, indicate the support required:

1 = Independent/Supervision 2 = Partial to Moderate Assistance 3 = Total Dependence

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Dressing |  | Toileting Hygiene |  | Bathing/Grooming |
|  | Eating/Drinking |  | Oral Hygiene |  | Hand washing |

**Mobility:**

For each item, indicate the support required:

1 = Independent/Supervision 2 = Partial to Moderate Assistance 3 = Total Dependence

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Ambulation |  | Transfers |  | Sit to stand |
|  | Mobility with use of aid (specify below) | | | | |

Mobility Aids: Wheelchair  Walker  Gait Belt  Other:

**Communication/Language:**

**Expressive:**

Makes self understood:  Usually  Sometimes  Rarely

Uses expressive language Mode:  Verbal  Sign Language  Gesture

Uses communication device Specify Type:

**Receptive:**

Ability to Understand Others:  Usually  Sometimes  Rarely

Comprehends verbal language  Attends to gestures and auditory cues  Attends to visual cues

Does not respond to communication

**Sleep:**

Average hours sleep per night:

Comments on sleep habits:

|  |
| --- |
| As needed, please provide any additional information relative to the applicants preferences, skills, or abilities. |

**SECTION V: BEHAVIORAL HEALTH**

Does the applicant currently require increased supervision as a special precaution?  Yes  No

If Yes, please explain:

Are any physical restraints\* currently in use with the applicant?  Yes  No

*\*Physical restraints are any manual method, physical or mechanical device, material or equipment that the individual cannot remove easily which restricts freedom of movement or normal access to one's body*

If Yes, please explain:

|  |  |  |  |
| --- | --- | --- | --- |
| **BEHAVIOR** | **Present** | | **DESCRIPTION** |
| **Yes** | **No** | Severity/Frequency/Circumstance/Directed at Staff, Self, or Other Residents? |
| Verbal Aggression |  |  |  |
| Physical Aggression |  |  |  |
| Property Destruction |  |  |  |
| Self-Injurious Behavior |  |  |  |
| Problematic Sexual Behavior |  |  |  |
| Accusatory Behavior |  |  |  |
| Elopement/Wandering |  |  |  |
| Noncompliance or resistance to treatment or care |  |  |  |
| Other: | | |  |
| Other: | | |  |
| **Symptoms of Psychosis** | | | |
| Delusions |  |  |  |
| Hallucinations |  |  |  |

**Known Social Stressors/Trauma History:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Substance Use** | **Yes** | **No** | **DESCRIPTION** (Severity/Frequency/Last known use) |
| Alcohol |  |  |  |
| Cigarettes/Tobacco |  |  |  |
| Other Substance Use |  |  |  |

**SECTION VI: OTHER INFORMATION**

|  |
| --- |
| Please provide any additional information needed for consideration of this referral. |

Completed referral, along with supporting documentation, should be submitted to: [DSOHF.NTC.Referrals@dhhs.nc.gov](mailto:DSOHF.NTC.Referrals@dhhs.nc.gov)