**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