

Facility Medical Record #: _____
 Last 4 of SSN: _____

Admitting State Hospital/ADATC: _____
 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 Self-Referral

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: _____
 Type of Admission: Voluntary MI SA Involuntary MI/SA
 Is Consumer Currently: Suicidal Homicidal
 Describe (attempts, thoughts, plans): _____
 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

*Route Codes: 1=Oral 2=Smoking 3=Inhalation 4=Injection 5=Other 9=Unknown
 **Frequency Codes: 0=Drug not used during past month 1=Drug used 1-3 times in past month 2=Drug used 1-2 times in past week 3=Drug used 3-6 times per week 4=Drug used daily

ASAM PPC-2R CRITERIA: FOR USE WITH ADATC REFERRALS

Please select the appropriate level:

Level II – INTENSIVE OUTPATIENT / PARTIAL HOSPITALIZATION SERVICES
 II.1 – Intensive Outpatient (more than 9 hours weekly)
 II.5 – Partial Hospitalization (20 or more hours weekly)

Level III – RESIDENTIAL / INPATIENT SERVICES
 III.3 – Clinically-Managed, medium intensity Residential Treatment (Extended Care, therapeutic rehabilitation facility)
 III.5 – Clinically-Managed, medium/high intensity Residential Treatment (Therapeutic Community, intensive structured treatment with ancillary services)
 III.7 – Medically-Monitored Intensive Inpatient Treatment (ADATC – sub-acute, transitional services)

III.9 – Medically Supervised Detox/Crisis Stabilization (ADATC – acute care hospital. Up to level IV behaviorally and level III.7 or below medically)

**** Lack of availability of appropriate, criteria-selected care and/or failure of a patient to progress at any given level of care may override the patient-treatment match with regard to levels of service.**

CONSUMER'S/PATIENT'S

NAME: _____

FEMALE ADATC REFERRAL: CHECK ALL THAT APPLY

ADATC Perinatal Referrals Do Not Require LME Authorization

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:

Axis I: _____

Axis II: _____ *Follow SB859 procedures for MR/DD referrals*

Axis III: _____

Axis IV: _____

Axis V: _____

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:

_____	Date of Last Dosage: _____
_____	Date of Last Dosage: _____
_____	Date of Last Dosage: _____
_____	Date of Last Dosage: _____
_____	Date of Last Dosage: _____
_____	Date of Last Dosage: _____

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: _____

Side Effects to Medications: _____

Allergies: _____

F History of Compliance with Medications: _____

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

BAC: _____ Time: _____

Labs Completed: _____

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 Contact: _____ Phone: () _____ Fax: () _____
) _____

(Hospital Liaison/Care Coordinator//Other LME Representative)

Assigned Psychiatrist: _____ Phone: () _____ Fax: () _____

Community Support 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:

Form completed by: _____
 _____ Signature _____
 _____ Date _____

- 1) _____
- 2) _____
- 3) _____

AUTHORIZATION BY THE LME: PRTF REFERRALS DO NOT REQUIRE AUTHORIZATION

<u>Referring County:</u> _____ <u>Phone#:</u> _____ <u>Authorization #:</u> _____ From: _____ To*: _____ Hospital Beds <input type="checkbox"/> Adult Admissions <input type="checkbox"/> Adults Long-Term <input type="checkbox"/> Geriatric Admissions <input type="checkbox"/> Adolescent Admissions <input type="checkbox"/> Child Admissions	<u>Responsible County:</u> _____ <u>Phone #:</u> _____ <u>Authorization #:</u> _____ From: _____ To*: _____ Hospital Beds <input type="checkbox"/> Adult Admissions <input type="checkbox"/> Adults Long-Term <input type="checkbox"/> Geriatric Admissions <input type="checkbox"/> Adolescents/Child Admissions <input type="checkbox"/> Child Admissions
ADATC Bed <input type="checkbox"/> Acute <input type="checkbox"/> Sub-Acute * Day Not Covered	ADATC Bed <input type="checkbox"/> Acute <input type="checkbox"/> Sub-Acute * Day Not Covered

FOR STATE FACILITY USE ONLY – IF NO AUTHORIZATION INFORMATION IS PROVIDED BY THE LME:

<u>Referring County:</u> _____ <u>Phone#:</u> _____ Hospital Staff Making Phone Call: _____ <input type="checkbox"/> No Response Within 1 Hour of Call If Response – Person Authorizing Days: _____	<u>Responsible County:</u> _____ <u>Phone #:</u> _____ Hospital Staff Making Phone Call: _____ <input type="checkbox"/> No Response Within 1 Hour of Call If Response – Person Authorizing Days: _____
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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.