Horizon House

Last, First Participant's Name: _____

Date of Birth: _____

ROBBINS BOWER
Crisis Residential Services Referral Form

REFERRAL SOURCE INFORMATION:

Date: _____ Time: _____

Person Making Referral: _____

Organization: _____ Contact #:_____

ADMISSION INFORMATION:

Demographics:

Gender: How do you identify? Male_____ Female_____ Specify:_____ SS#_____

Address:_____

County:_____ Phone #: _____

Can the individual return to the residence? ☐ Yes ☐ No

Is there a known bedbug infestation at this location? ☐ Yes ☐ No

(A yes answer will not preclude admission)

Coordination of Care:

MA Recipient#:_____ Eligibility Verified?: ☐ Yes ☐ No

Psychiatrist Name: _____ Telephone #:_____

Primary Care Physician:_____ Telephone #:_____

ACT/ICM worker: _____Telephone#: _____

Emergency Contact: _____ Phone #: _____

Admission Criteria:

DSM V/ ICD 10 Diagnosis

Code: _____ Description: _____

Code: _____ Description: _____

What is the presenting problem? What does the participant hope to gain from stay?

_____

_____

_____

_____

_____

Accessibility/Self Preservation:

Is the participant hearing impaired?	Y☐	N☐
Is their primary language other than English?	Y☐	N☐
Do they need assistance to ambulate on steps?	Y☐	N☐
Do they need assistance with ambulation?	Y☐	N☐
Do they use a wheelchair?	Y☐	N☐
Do they need assistance with ADL's?	Y☐	N☐

Challenging Behaviors:

Is the participant currently threatening or violent?	Y☐	N☐
Do they have a history of violence?	Y☐	N☐
Do they have suicidal and/or homicidal ideation?	Y☐	N☐
Do they currently have any self-injurious behaviors?	Y☐	N☐
Is the participant currently using drugs/alcohol?	Y☐	N☐
Does the participant have legal charges pending?	Y☐	N☐
Are they a registered sex offender?	Y☐	N☐
Do they have a history of arson?	Y☐	N☐

Please explain all yes responses:

_____

_____

_____

_____

_____

Last, First Participant's Name: _____

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MEDICAL INFORMATION:

General Medical:

Are there any known allergies? ☐ Yes ☐ No

Is the participant receiving a long-acting injection? ☐ Yes ☐ No

Date of last injection _____ ***Date next due*** _____

Is the participant currently on Clozaril ? ☐ Yes ☐ No

Are they diabetic? ☐ Yes ☐ No

Are they currently pregnant? ☐ Yes ☐ No

Do they have any acute medical concerns or treatment? ☐ Yes ☐ No

Please explain all yes responses:

_____

_____

_____

Current Medication: Identify all current medications: psychiatric and medical or check: ☐ See Attached Med List

_____

_____

_____

_____

*At admission, must come in with at least 7 day supply of medical meds or prescription

Medical Clearance:

Do they present with a communicable disease that can be spread by causal contact?

☐ No ☐ Yes, please specify: _____

Has the participant been medically cleared**?** ☐ Yes ☐ No

Attach the following most recent documentation(s) if available:

- ☐ Psychiatric evaluation
- ☐ Psychosocial History
- ☐ Physical Examination
- ☐ Current list of Medications
- ☐ UDS/BAL (current or past 30 days use/abuse)
- ☐ UTI/Pregnancy Screen (As applicable)
- ☐ Current Lab work
- ☐ Signed Releases of Information for any previous treatment/hospitalizations

Referring Staff Signature: _____ Date: _____