**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:_____ ☐ **Consumer is Deaf or Hard of Hearing and uses American Sign Language as primary means of communication**

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 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***

*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:**

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**:

_____ 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: _____
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)**_____

**2)** _____

**3)**_____

Form completed by:_____
Signature

_____ _____
Title Date

**AUTHORIZATION BY THE LME/MCO: PRTF REFERRALS DO NOT REQUIRE AUTHORIZATION**

***Referring*** **County:_____ Phone#:_____**
**Authorization #**:_____ From:_____ To*:_____

**Hospital Beds**
- ☐ Adult Admissions
- ☐ Adults Long-Term
- ☐ Geriatric Admissions
- ☐ Adolescent Admissions
- ☐ Child Admissions

**ADATC Bed**
- ☐ **Crisis**
- ☐ **Inpatient**

* Day Not Covered

***Responsible*** **County:_____Phone #:_____**
**Authorization #**:_____ From:_____ To*:_____

**Hospital Beds**
- ☐ Adult Admissions
- ☐ Adults Long-Term
- ☐ Geriatric Admissions
- ☐ Adolescents/Child Admissions
- ☐ Child Admissions

**ADATC Bed**
- ☐ **Crisis**
- ☐ **Inpatient**

* Day Not Covered

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

***Referring*** **County:_____ Phone#:_____**
**Hospital Staff Making Phone Call:_____**
☐ No Response Within 1 Hour of Call
If Response – Person Authorizing Days:_____

***Responsible*** **County:_____Phone #:_____**
**Hospital 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.**