

Area Program Medical Record #: _____

Hospital Medical Record #: _____

REGIONAL REFERRAL FORM

Area Program: **Western Highlands LME**

Date: _____ Time: _____

Client's Name: _____
Last First Middle/Maiden

MR/DD No Yes Social Security #: _____

Client's Address _____

Responsible Party's Name and Address _____

Responsible Party's Telephone Number: Home: (____) _____ Work: (____) _____

Date of Birth: _____ Race: _____ Commitment Type: _____
MM DD YY

BEFORE ADMISSION CALL:

Referring County: _____ Phone: _____	Responsible County: _____ Phone: _____
Time of Phone Call: _____	Time of Phone Call: _____
Hospital Staff Making Phone Call: _____	Hospital Staff Making Phone Call: _____
<input type="checkbox"/> No Response Within 1 Hour of Call:	<input type="checkbox"/> No Response Within 1 Hour of Call:
If Response – Person Authorizing Days: _____	If Response – Person Authorizing Days: _____
Authorization: _____ From: _____ To: _____	Authorization: _____ From: _____ To: _____
Hospital Beds <input type="checkbox"/> ADATC/SA Bed	Hospital Beds <input type="checkbox"/> ADATC/SA Bed
<input type="checkbox"/> Adult Admissions	<input type="checkbox"/> Adult Admissions
<input type="checkbox"/> Adult Long-term	<input type="checkbox"/> Adult Long-term
<input type="checkbox"/> Geriatric Admissions	<input type="checkbox"/> Geriatric Admissions
<input type="checkbox"/> Adolescents/Child Admissions	<input type="checkbox"/> Adolescents/Child Admissions

2. TO BE COMPLETED BY REFERRING PROVIDER: Provider Name _____

Presenting Problem: _____

If currently using: Alcohol Drug Alcohol & Drug Specify: _____ ASAM Level _____

Include Substance Dependence, Psychiatric Diagnoses and Medical Conditions:

Axis I: _____

Axis II: _____

Axis III: _____

History of Treatment: _____

Previous Admission to Any State Facility (Place and Date): _____

Alternatives Attempted/Considered Prior to Referral to Hospital: _____

Medical History Heart Disease Hypertension Diabetes Seizure Disorder Other

Comments: _____

CLIENT NAME: _____ Date: _____

*Current Medications (medical and psychiatric). Include last injection date, side effects, history of compliance, recent lab work, aftercare instructions:

*Client Allergies _____

Client Adjudicated Incompetent/Minor: _____ Date Adjudicated: _____ If yes, type of guardianship: _____

Pending Legal Charges: Yes No Detainer (County) _____
 Unknown Other _____

House Bill 95: Yes No Veteran Yes No Senate Bill 433 (NGRI): Yes No

Area Program Staff to Call for Further Information:

Primary Contact _____ Phone _____

Secondary Contact _____ Phone _____

After Hours Phone: _____ Fax Number: _____

Psychiatrist: _____ Phone: _____

Third party coverage: Medicaid #: _____ Medicare #: _____ Other: _____

Insurance Co.: _____ Policy Holder: _____ Policy Number: _____

Goal of Hospitalization and Treatment Objectives:

Specific Suggestions for Programming/Treatment Planning:

Release Plans and Placement Considerations:

Relevant Family/Guardian and Social Supports:

Name:	Address	Phone #	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

Discharge Plan: _____

Form Completed By: _____ Date: _____

ASAM Level III.7 Admission Checklist

Patient must meet diagnostic criteria for substance dependence in at least **two** of the following five dimensions:

- DIM 2** Continued use places patient in imminent danger/serious damage to physical health or concomitant biomedical conditions (i.e., pregnancy) _____
or
Biomedical complications of addiction or concomitant conditions require medical monitoring _____
- DIM 3** Depression and/or other emotional behavioral symptoms interfere with abstinence/recovery such that intense structure milieu management is needed _____
or
Moderate risk of harm to self or others _____
or
Family/work/social stress interferes with activities of daily living (ADL) so much that a 24 hours setting is needed. _____
or
History/presence of violent/disruptive behavior while intoxicated, posing imminent danger to self/others _____
or
Concomitant personality disorder so severe that continuous boundary setting is needed. _____
- DIM 4** Despite serious consequences, patient does not accept or relate addiction to problems _____
or
Patient needs intensive motivating strategies, activities and processes available only in a 24 setting _____
- DIM 5** Despite outpatient treatment (including 12 step groups) patient is in crisis and symptoms are intensifying; requires 24 hour setting. _____
or
Patient recognizes use is excessive, has tried to reduce or control, but can't when substances are in environment _____
or
Modality of treatment can only occur inpatient (aversion treatment, etc) _____
- DIM 6** Patient lives in environment where treatment won't succeed _____
or
Patient has no access to lower level because of logistics _____
or
Danger of physical/sexual abuse in environment _____
or
Patient is in occupation where continued use places society in danger (air traffic controller, etc) _____

Signature/Title _____