

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 3=Drug used 3-6 times per week  
 1=Drug used 1-3 times in past month 4=Drug used daily  
 2=Drug used 1-2 times in past week

**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: \_\_\_\_\_

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 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:**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Form completed by: \_\_\_\_\_

Signature

Title

Date

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

<b>Referring County:</b> _____ <b>Phone#:</b> _____ <b>Authorization #:</b> _____ <b>From:</b> _____ <b>To*:</b> _____ <b>Hospital Beds</b> <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	<b>ADATC Bed</b> <input type="checkbox"/> Acute <input type="checkbox"/> Sub-Acute  * Day Not Covered	<b>Responsible County:</b> _____ <b>Phone #:</b> _____ <b>Authorization #:</b> _____ <b>From:</b> _____ <b>To*:</b> _____ <b>Hospital Beds</b> <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	<b>ADATC Bed</b> <input type="checkbox"/> Acute <input type="checkbox"/> Sub-Acute  * Day Not Covered
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**FOR STATE FACILITY USE ONLY – IF NO AUTHORIZATION INFORMATION IS PROVIDED BY THE LME:**

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