

# Regional Assessment and Referral Form

REFERRAL INFORMATION		
Staff Taking Referral:	Date and Time:	
Referral Agency:	Referral Source's Name:	
Phone Number:	Fax Number:	
Outpatient Psychiatrist:	Outpatient Provider:	
Follow up appointment scheduled? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, where and when and telephone number?	Voluntary <input type="checkbox"/>  Involuntary <input type="checkbox"/>	Was involuntary paperwork sent to this facility? Yes: <input type="checkbox"/> No: <input type="checkbox"/>

HISTORY AND DEMOGRAPHIC INFORMATION			
Name:	Age:	DOB:	SSN:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female → Pregnant? <input type="checkbox"/> Yes	Phone:		County of Residence:
Address:	City:	State:	Zip:
Ethnicity: Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other :			
Primary Language: English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		English Proficiency: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Marital Status:	Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner <input type="checkbox"/>		
Resides with:	Family <input type="checkbox"/> Alone <input type="checkbox"/> Friend <input type="checkbox"/> Retirement/Asst Living/Nursing Home <input type="checkbox"/> Homeless <input type="checkbox"/> Shelter <input type="checkbox"/> Foster Home/Group Home Level ____ <input type="checkbox"/> Can Return to Above: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Educational Level:	Veteran: Yes <input type="checkbox"/> No <input type="checkbox"/>	Active Military Yes <input type="checkbox"/> No <input type="checkbox"/>	
Guardian:	Phone:	POA/HCP/A:	Phone:
Emergency Contact:	Relationship to Patient:		Phone:

INSURANCE INFORMATION			
Private:	Self-Pay:	Medicaid #:	Medicare #:
Insurance Company:		Insured's Name:	Insured's DOB:
Policy #:	Group #:	Insured's SS#:	Employer:
Ins. Phone#:		<input type="checkbox"/> Fax front and back of Insurance Card	

CLINICAL INFORMATION	
<b>RISK FACTORS</b>	
<b>Suicidality:</b> <input type="checkbox"/> None <input type="checkbox"/> Threats <input type="checkbox"/> Impulsive <input type="checkbox"/> Plan: _____ <input type="checkbox"/> Previous Attempts: _____ <input type="checkbox"/> Self Injurious Behaviors: _____ <input type="checkbox"/> Command hallucinations to harm self: : _____ Self-harm Risk: Under patient's control <input type="checkbox"/> Poorly controlled but not imminently dangerous <input type="checkbox"/> Imminently dangerous <input type="checkbox"/>	
<b>Violence:</b> <input type="checkbox"/> None <input type="checkbox"/> HI <input type="checkbox"/> Threats <input type="checkbox"/> Impulsive <input type="checkbox"/> Plan: _____ <input type="checkbox"/> Property Destruction: _____ <input type="checkbox"/> Recent Violence Towards Others: _____ <input type="checkbox"/> Command hallucinations to harm others: : _____ Violence Risk: Under patient's control <input type="checkbox"/> Poorly controlled but not imminently dangerous <input type="checkbox"/> Imminently dangerous <input type="checkbox"/>	

<b>Reason for Referral</b>

<b>Past Psychiatric History (Hospitalizations and Outpatient Treatment):</b>

**Substance Use:**

Tobacco Use:  Current Drug Use:  Need Detox: Yes  No

Substance	Frequency	Duration	Last Use	History of serious withdrawal	
Alcohol				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Benzodiazepines				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Barbiturates				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cocaine				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Methamphetamine				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hallucinogens				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Marijuana				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Opiate				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other:					

Past Outpatient Attempts: \_\_\_\_\_

Past Detox or Rehab admissions – List Dates: \_\_\_\_\_

Hx of DT's or Seizures: Yes  No  If Yes, Last Date of DT's or Seizure \_\_\_\_\_

CIWA Score: \_\_\_\_\_  Nausea  Vomiting  Sweats  Agitation  Anxiety  Disoriented  Headache  
 Tremor  Tactile/Visual/Auditory Disturbances  Diarrhea  Muscle Cramping

**Medical History:**

History of Traumatic Brain Injury: Yes  No

Confirmed Mental Retardation: Yes  No

Mild  Moderate  Severe  IQ Deficits **and**

Mild  Moderate  Severe  Adaptive Deficits

Allergies:

Current Medications	Dosage	Frequency	Compliance Issues	Prescriber

Were the following labs and patient information sent in to this facility?

Vital Signs:  
Yes:   
No:

CBC:  
Yes:   
No:

CMP:  
Yes:   
No:

UDS:  
Yes:   
No:

BAL:

Height:

Weight:

**ADL's**

Feeds self	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Gait Stable	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bathes self	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ambulatory	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Continent of Urine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Assistance Needed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Continent of Bowel	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fall History	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Current/Pending Legal charges and Court Dates:**

**Legal History (Including Incarceration History):**

Probation/Parole Officer Name:

Phone Number:

## Mental Status Exam

(If accepted in the Emergency Department)

**Dress/Appearance:**  Unremarkable  Disheveled  Eccentric  Inappropriate for Conditions  Poor Hygiene

**Sleep:**  Rested  More Than Usual  Poor **Appetite:**  Typical  More Than Usual  Less Than Usual

**Attitude:**  Cooperative  Withdrawn  Guarded  Suspicious  Uncooperative  Manipulative

**Motor Activity:**  Unremarkable  Slowed  Repetitive  Restless  Agitated  Tremor  Catatonic

**Affect:**  Appropriate  Labile  Constricted  Blunted  Flat  Inappropriate

**Mood:**  Euthymic  Depressed  Anxious  Euphoric  Irritable  Angry

**Speech:**  Unremarkable  Over-talkative  Spontaneous  Impoverished  Slow  Pressured  Loud  
 Soft  Monotone  Slurred  Aphasic

**Thought Process:**  Unremarkable  Vague  Incoherent  Circumstantial  Tangential  Perseverative  
 Flight of Ideas  Loose Associations  Self-contradictory

**Thought Content :**  Goal Oriented  Obsessions  Compulsions  Ruminations  Phobias

**Delusions:**  None  Paranoia  Persecution  Infidelity  Grandiose  Somatic  Thought Insertion  
 Thought Broadcasting  Erotomanic

**Hallucinations/Illusions:**  None  Tactile  Visual  Auditory  Olfactory  Taste

**Trauma:**  None  Sexual  Physical  Emotional  Military  Significant Death  Natural Disaster  
 Health Condition  Refugee  Other: \_\_\_\_\_

**Trauma Reaction:**  Depersonalization  Derealization  Fugue  Nightmares  Hallucination/Re-experiencing  
 Socially Avoidant  Hypervigilant  Limited Dissociation  Dissociative Identities

**Consciousness:**  Alert  Drowsy  Dull  Intoxicated **Not Oriented:**  Person  Place  Time  Situation

**Cognition:**  Effective  Distractible  Concentration Problem  Short-term Memory Deficit  
 Long-term Memory Deficit  Poor Problem Solving  No Insight Into Problem

**Judgment:**  Intact  Poor  Impulsive  Impaired

**Motivation:**  Unmotivated  Minimizing  Contemplating  Preparing  Action Oriented

**Current Diagnostic and Level of Care Impressions (If known and required by referring or accepting facility):**

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: GAF \_\_\_\_\_ or LOCUS, CALOCUS, or ECSII Level: \_\_\_\_\_ ASAM Score (SA Referral): \_\_\_\_\_

**Recommendations:**

**Disposition:**

- Inpatient Program \_\_\_\_\_  Crisis Stabilization Unit: \_\_\_\_\_  
 Detox Program \_\_\_\_\_  Partial Hospitalization / IOP \_\_\_\_\_  
 Discharge to \_\_\_\_\_  Referral to Other \_\_\_\_\_

Accepting MD or Medical Provider and Facility Name: \_\_\_\_\_

<b>Law Enforcement Observation Tool (LEOT)</b>  <b>Circle the number(s) that apply to patient's ED presentation, add scores, and total below</b>	After ED arrival, patient fights or attempts to flee from custody	5	Aggression leading to ED visit significantly harmed another	5	Extremely belligerent and verbally threatening others in ED	2
	Client has known history of harm to law enforcement or hospital staff	5	Racing, uncontrollable, and commanding psychotic thoughts	3	Extreme emotions driving impulsive actions	2
	Before ED arrival, patient fights or attempts to flee from custody	5	Destroying property in ED	3	Currently intoxicated or "high" to the point of loss of self-control	2
<b>Total Points:</b>			<b>0 to 4 points</b> – ED staff observation during assessment could be sufficient	<b>5 or more points</b> – Law enforcement observation would likely be needed		

**Complete this section ONLY IF considering, 3-Way Psychiatric Hospital, or State Facility:**

Reasons recent tx not successful:  No Meds/Not Taken/Abused/Sold  OP Provider Issue  Traumatic Life Event  
 Symptom Acuity  Abuse/Neglect  Substance Use  Needed Higher LOC  Other: \_\_\_\_\_

Other prior tx:  Med-only  OP therapy  OP Enhanced  Residential  Crisis Unit  Hospital x \_\_\_\_\_?

Treatment Goals:  Med Stabilization  Harm Reduction  Tx and Crisis Plan Dev.  OP Follow-up

Other: \_\_\_\_\_

Discharge Plan (ONLY if known):

OP Provider: \_\_\_\_\_ OP Medication Follow-up: \_\_\_\_\_

D/C to what residence?: \_\_\_\_\_ Transportation by whom?: \_\_\_\_\_

**Authorization Number:** \_\_\_\_\_  
**(Given By Managed Care Organization)**