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Crisis/Acute Services Referral and Admission Form

Crisis New Haven ☐
Fax: 203-752-8712

Crisis Bridgeport ☐
Fax: 475-282-4988

CTS-Step Down/ACT Team ☐
Fax: 475-227-3956

Date of Referral: _____ Previous Respite Stay? Yes☐ No☐

Name: _____ SS#_____-_____-_____

DOB_____ Age _____ Gender: ☐Male ☐Female ☐Unspecified

Address: _____ City: _____State:____ Zip Code:_____

Home Phone: (_____) _____ Other Phone: (____) _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

*Reason for Referral: _____

Referral Source (Name/Agency): _____Referral Phone:_____

Demographics:
Current Living Situation: _____

Race: _____ Ethnicity: Hispanic ☐ Non-Hispanic ☐

Marital Status: Divorced ☐ Married ☐ Never Married ☐ Separated ☐ Other ☐

Veteran Status: Yes ☐ No ☐ Unspecified ☐

Employment Status: F/T ☐ P/T ☐ SSI/SSDI ☐ Unemployed ☐

Insurance Information:
Policy Number: _____ Type: _____

DIAGNOSIS INFORMATION (Clinicians <u>MUST</u> provide both code and name)

AXIS I: _____.____ _____; _____.____ _____
AXIS I: _____.____ _____; _____.____ _____
AXIS II: _____.____ _____; _____.____ _____
AXIS III/Medical: _____.____ _____; _____.____ _____
AXIS V/GAF: _____

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DISCHARGE and CLINICAL AGREEMENT:

The following is an acknowledgement and agreement that all parties have discussed the Crisis admission procedures, the services to be provided by the Crisis team, and **that a discharge plan is in place and has been agreed upon prior to admission.** Length of stay with the Crisis programs may not exceed 14 days. The Crisis programs are not responsible for securing housing/permanent residence.

As the clinical provider I am aware of the LOS limitations and understand that in preparation for discharge the client will have alternative living arrangements in place, including the local shelter if no alternative plans are in place.

Based on my clinical evaluation and to the best of my knowledge, the client being referred:

- is not a danger to him/herself or others and is able and willing to participate in the program;
- is able to meet basic ADL skills including caring for him/herself;
- is not under the influence of illicit drugs/alcohol or has not used substances in the last 24 hours;
- is able to self-administer medications and is medically stable;
- has not been arrested/incarcerated for a violent crime, sexual offense, or arson; and
- includes information that is, to the best of my knowledge, complete and correct.

☐ **By checking this box, I, the referring party, acknowledge the client is in need of observation in their self-administration of medication. Staff cannot support in this oversight without acknowledgement.**

Name of MD (Print): _____

MD Signature: _____ Date: _____

Name of Clinician (Print):_____

Clinician Signature: _____ Date: _____

Name of Homecare Provider (if applicable): _____ Phone: _____

By providing the following documents, you do not need to fill out the demographic information on pg. 1 of this referral. Continuum staff has the right to conduct screening and ask additional questions about the client's clinical presentation prior to admission. Admission is dependent upon bed availability and appropriateness for the program.

Please check off the documents submitted for admission:

☐ Psychiatric Evaluation
☐ Updated Medication List
☐ W-10 or Discharge Paperwork
☐ Recent Toxicology Screen
☐ Crisis/Acute Services Discharge Agreement
☐ Other: _____

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Crisis/Acute Services Client Discharge Agreement

- I have been honest about my criminal involvement; including any outstanding warrants or pending convictions.
- I have been evaluated within the past 24 hours by a clinician.
- I am able to perform basic activities of daily living.
- I am not under the influence of drugs and/or alcohol.

I am willing to participate in the Crisis program voluntarily. By signing this form, I have agreed with the discharge plan as outlined and will adhere to the Crisis environments procedures of operations and length of stay. I understand that these procedures will be reviewed with me with a Continuum representative as part of the admission process.

*Please note: Any medications left behind will be destroyed 30 days after discharge date.

Agreed plan of discharge: _____

_____

Client Name (Print):_____Date:_____

Client Signature: _____Date:_____

Signed when reviewed upon admission with client:

Continuum Rep. Name (Print):_____Date:_____

Signature:_____Date:_____