Crisis/Acute Services Referral and Admission Form

Crisis New Haven ☐ Fax: 203-752-8712
Crisis Bridgeport ☐ Fax: 475-282-4988
CTS-Step Down ☐ Fax: 475-227-3956

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

Name: ___________________________________ SS#_________-________-____________

DOB____/_____/_____ Age ______ Gender: ☐ Male ☐ Female ☐ Transgender ☐ 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 (provide both code and name)

Diagnosis ______________________________________ **ICD-10/DSM Code: ________.______**

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Diagnosis ______________________________________ **ICD-10/DSM Code: ________.______**

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

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 Continuum Crisis program voluntarily. I understand that Continuum of Care and Yale New Haven Health Services shall coordinate care by accessing my electronic record in EPIC specifically only to the care provided during my term with Continuum.

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 and include, but are not limited to, the following:

- I will call 211 within 48 hours of entering the program if shelter is part of my discharge plan
- If I refuse to call 211 or complete the CAN assessment, I will forfeit my bed at the program
- If my discharge plan includes shelter and a CAN bed is offered to me, I will forfeit my bed at the program if I decline to accept the CAN bed.

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

Agreed plan of discharge: ____

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Client Name (Print):____Date:__________

Client Signature: ____Date:__________

Signed when reviewed upon admission with client:

Continuum Name (Print):_______________________________________Date:____________

Signature:____Date:____________