



**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  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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**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:

- |  |  |
|--|--|
| <input type="checkbox"/> Psychiatric Evaluation      | <input type="checkbox"/> Recent Toxicology Screen                  |
| <input type="checkbox"/> Updated Medication List     | <input type="checkbox"/> Crisis/Acute Services Discharge Agreement |
| <input type="checkbox"/> W-10 or Discharge Paperwork |  |



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

\_\_\_\_\_

Client Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Signed when reviewed upon admission with client:**

Continuum Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_