CATC/RESPITE REFERRAL FORM

PLEASE FAX COMPLETED FORM TO **503-988-0310** OR SCAN TO **CATCREFERRALS@MULTCO.US** or **RESPITEREFERRALS@MULTCO.US**

PLEASE INCLUDE ALL OF THE FOLLOWING ALONG WITH A **COMPLETED REFERRAL FORM** FOR ADMISSION. **INCOMPLETE FORMS OR DOCUMENTS WILL DELAY PROCESSING THE REFERRAL**.

FOR CATC: REQUIRED DOCUMENTS INCLUDE MENTAL HEALTH ASSESSMENT, CLINICAL PROGRESS NOTES FROM LAST 24 HOURS, MEDICATION LIST, HEALTH AND PHYSICAL, AND ALL LABS.

FOR RESPITE: REQUIRED DOCUMENTS INCLUDE MENTAL HEALTH ASSESSMENT, CURRENT PROGRESS NOTES, SIGNED MEDICATION ORDER, HEALTH SCREENING, SUPPLEMENTAL COVID-19 SCREENING FORM. CL WILL NEED A 7-14 MEDICATION SUPPLY UPON ARRIVAL. PERSONAL EFFECTS AT RESPITE ARE LIMITED TO A 2 BAG MAXIMUM.

CATC: RESPITE: BOTH:

CATC/Respite Referral Screening to be filled out by Referent

Potential Resident Name: _____

Name of Insurance: _____ Insurance ID: _____

Name of Referent: _____ Referent Phone Number: _____

Referral Source (Location and Department):

Patient Information:

Date of Birth: _____ Age: _____ Gender: _____ Race: _____

Address: _____

Multnomah County Resident: ☐Yes ☐No

Probation? ☐Yes ☐No _____ Parole? ☐Yes ☐No _____ Guardian? ☐Yes ☐No _____

If Yes complete parole/probation and/or Guardian info below:

Name: Address Phone:

Legal Status:

☐Voluntary ☐NMI/ Date: _____ ☐Trial Visit ☐14 Day Diversion ☐Court Commitment

ICP Investigator Name
phone number: _____

Presenting Problem and Symptoms:

Psychiatric Need/Presentation (disorganization, acute psychosis): ☐Yes ☐No if yes please describe:

CATC/Respite expected outcome:

Has a Discharge plan been started? I.e. respite, outpatient, housing:

Primary Care Provider (PCP)/Phone number:

Mental Health Provider/Phone number _____

Emergency Contact/Phone number _____

Mental Health Assessment completed within the last 24 hours and available: ☐No ☐Yes ☐Unknown

Physical Assessment completed within last 30 days and available: ☐No ☐Yes ☐Unknown

PPD/TB test completed within last 12 months and available: ☐No ☐Yes ☐Unknown

Hepatitis B screening test completed and available within the last 12 months: ☐No ☐Yes ☐Unknown

Ambulatory/can evacuated by stairs within 3 minutes independently: ☐No ☐Yes ☐Unknown

Can cl walk unassisted? ☐Yes ☐No

Can cl use stairs unassisted? ☐Yes ☐No

Is cl able to follow evacuation directions in an emergency? ☐Yes ☐No

Is cl able to complete activities of daily living (ADLs):

Any episodes of incontinence (bladder/bowel) during this admit?☐Yes ☐No

If so, was cl able to manage the clean-up of the episode independently? ☐Yes ☐No

Does the cl take showers without assistance?☐Yes ☐No

Does the client need a prompt to shower/change clothes? ☐Yes ☐No

Does cl need 1:1 care? ☐Yes ☐No

Substance Use History: (frequency/last date of use):

Date of last UDS:_____ Results:

Medical Disorders:

Are they taking medications for medical disorders? ☐Yes ☐No

Allergies:

Any issues with bed bugs in last 12 months ☐Yes ☐No Lice? ☐Yes ☐No Scabies? ☐Yes ☐No

ICD 10./DSM 5 Provisional Diagnosis:
Primary:

Secondary

Tertiary:

Areas of Risk:

Suicidal Risk? (intent, thoughts, etc.) ☐Yes ☐No if yes please describe:

Previous Attempts? ☐Yes ☐No if yes please describe:

Current Plan/Means? ☐Yes ☐No if yes please describe:

Able/willingness to remain safe in current setting ☐Yes ☐No if no please describe:

Dangerousness/Violence/Combativeness towards others ☐Yes ☐No if yes please describe:

Does cl disrupt milieu with verbal or physical outburst?
☐Yes ☐No If yes, please describe:

History of Sexual Behaviors and/or Vulnerability (sexual preoccupation, hyper sexuality, sexual trauma, history of sexual offence, other sexual behaviors that require monitoring/mitigation while in facility)
☐Yes ☐No if yes please describe:

Additional Providers/Supports:

MH TX TEAM: Phone: FAX:

Psychiatric Provider:

Pharmacy:

Upcoming appointments in next 7 days: