

REFERRAL FORM

****NOTE: ALL questions must be answered** (Indicate N/A where applicable)

DATE OF REFERRAL: Click or tap to enter a date.		TIME OF REFERRAL: Click or tap to enter a date. <input type="checkbox"/> AM <input type="checkbox"/> PM	
REFERRAL INFORMATION			
Referred by: Click or tap here to enter text.		Direct Telephone #: Click or tap here to enter text.	
Referring Agency: Click or tap here to enter text.		Date of Admission to Referring Agency: Click or tap here to enter text.	
Case Manager: Click or tap here to enter text.		Telephone No: Click or tap here to enter text.	
CLIENT INFORMATION			
Name: Click or tap here to enter text.		DOB: Click or tap to enter a date.	SSN: Click or tap here to enter text.
Address: Click or tap here to enter text.			
Telephone No.: Click or tap here to enter text.			
Primary Care Provider: Click or tap here to enter text. <small>(Name, address & Telephone No.)</small>			
Mental Health Provider: Click or tap here to enter text. <small>(Name, address & Telephone No.)</small>			
Insurance Type: Click or tap here to enter text.		Insurance Number: Click or tap here to enter text.	
ELIGIBILITY SCREENING			
Next Preliminary Court Hearing Required by Date: Click or tap here to enter text.		Type of Hold: <input type="checkbox"/> 90d <input type="checkbox"/> 180d <input type="checkbox"/> RLRA	
County of the Hearing: Click or tap here to enter text. Is Shelton Next Steps approved on the ITA paperwork? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does client have a history of violence?		<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe: Click or tap here to enter text.	
Does client have a history of suicide?		<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe: Click or tap here to enter text.	
Is client a registered sex offender?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Is client on DOC Supervision?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, please provide name/contact of supervising office: Click or tap here to enter text.			
MENTAL HEALTH DIAGNOSIS (Include DCM V and ICD-10 code and labels)			
Click or tap here to enter text.			
MEDICAL DIAGNOSIS (ICD-10 codes and labels for Physical Health)			
Click or tap here to enter text.			

CLINICAL HISTORY

Reason for referral (Please include precipitating event and current symptoms):

Click or tap here to enter text.

Legal Guardian/DPOA? YES NO

If yes, please provide Name, Address and Telephone No. Click or tap here to enter text.

Does client have a substance abuse history? Yes No **If yes, answer additional questions below:**

• Drugs used (including alcohol): Click or tap here to enter text.

• Date of last use: Click or tap to enter a date.

• Participating in MAT? Yes No If yes, what medication? Click or tap here to enter text.
**Note: Cannot Serve Clients on Methadone Maintenance*

What is the Client’s Assessed Fall Risk? Low Medium High

Is the Client incontinent? Yes No

Can Client perform ADLs without assistance? Yes No

Is Client ambulatory without an assistive device? Yes No

ALLERGIES: Click or tap here to enter text.

Is Client Diabetic? Yes No If so, how is blood sugar controlled? Click or tap here to enter text.

Does Client use a CPAP? Yes No

List of current medications:
Click or tap here to enter text.

Is there a Compelled Medication Order in place? Yes No If yes, please provide a copy Court Order. Click or tap here to enter text.

Has a “Clear” COVID-19 screening been completed? Yes No

CURRENT MENTAL STATUS

Alert/Oriented	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Thought Process	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Speech	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Delusions	<input type="checkbox"/> Present	<input type="checkbox"/> Not Present
Behavior	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Suicidal Ideation	<input type="checkbox"/> Present	<input type="checkbox"/> Not Present
Self-injurious Behavior	<input type="checkbox"/> Present	<input type="checkbox"/> Not Present	Homicidal Ideation	<input type="checkbox"/> Present	<input type="checkbox"/> Not Present

Explain any abnormalities:
Click or tap here to enter text.

DISCHARGE PLANNING

The client should consent to placement and be a candidate for placement if finding placement is the justification for transfer to the Next Steps Program. Clients should not be promised any outcome until the appropriate housing and/or resource assessments have been completed as not all will qualify for additional services.

What is the intended purpose of the transfer? Additional Stabilization Arrange Placement Long Term Care

Does the client consent to and participate in discharge planning? Yes No Unable

Where does the client want to go when they are discharged? Click or tap here to enter text.

Does the client have any supports that can assist them after discharge? Family Friends Outpatient Programs

List Supports & Contact Information: Click or tap here to enter text.

Does the client consent to housing placement if indicated? Yes No Unable

Has a housing assessment been completed? Yes No Unable

Does the client have an MCO Case Worker? Yes No Contact Info: Click or tap here to enter text.

Does the patient qualify for and have accepted to any of the following services? GOSH DSHS/HCS AFH

If going to an AFH, what is their expected daily rate? Click or tap here to enter text.

Does the client need the following? ID Birth Certificate Phone Social Security Card Bank / Debit / Credit Card Other: Click or tap here to enter text. Has the process to obtain been started? Yes No

Medications and Labs

****Please attach all current medication orders and most recent Labs****

****Transfers should be sent with all ITA paperwork (including initial petition for detention and prior holds), updated provider notes, discharge orders, a few days supply of prescribed medications (other than OTC), as well as an up to date copy of the patient's MAR.****

REFERRAL CHECKLIST: *The following documents MUST be received prior to final approval

<input type="checkbox"/> Referral Form	<input type="checkbox"/> Toxicology Screen
<input type="checkbox"/> Initial Detention Authorization (From DCR)	<input type="checkbox"/> Verification of stable Vitals
<input type="checkbox"/> Custody Authorization Court Order	<input type="checkbox"/> H&P Report within 30 days
<input type="checkbox"/> Civil Commitment Court Order – 90 or 180 Day	<input type="checkbox"/> Most recent labs including for medication levels
<input type="checkbox"/> Last 14 days of Psychiatric Evaluations and Progress Notes	<input type="checkbox"/> Discharge Summary as soon as available
<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Last 14 days Medical Progress Notes
<input type="checkbox"/> Medications Orders signed by MD or ARNP	<input type="checkbox"/> MARS
<input type="checkbox"/> Admit Medical H&P	

ONS STAFF USE ONLY:

Date/Time Referral Received: Click or tap to enter a date.

Staff Initials: _____

Accepted Declined

***If Denial, provide rationale.**
