Telecare Corporation

Secure Email / Send Referrals to:
nextsteps@telecarecorp.com

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. ☐ **AM** ☐ **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.
(Name, address & Telephone No.)

Mental Health Provider: Click or tap here to enter text.
(Name, address & Telephone No.)

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: ☐ 90d ☐ 180d ☐ RLRA

County of the Hearing: Click or tap here to enter text. Is Shelton Next Steps approved on the ITA paperwork? ☐ Yes ☐ No

Does client have a history of violence? ☐ **YES** ☐ **NO** If yes, describe: Click or tap here to enter text.

Does client have a history of suicide? ☐ **YES** ☐ **NO** If yes, describe: Click or tap here to enter text.

Is client a registered sex offender? ☐ **YES** ☐ **NO**

Is client on DOC Supervision? ☐ **YES** ☐ **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	☐ Normal	☐ Abnormal	Thought Process	☐ Normal	☐ Abnormal
Speech	☐ Normal	☐ Abnormal	Delusions	☐ Present	☐ Not Present
Behavior	☐ Normal	☐ Abnormal	Suicidal Ideation	☐ Present	☐ Not Present
Self-injurious Behavior	☐ Present	☐ Not Present	Homicidal Ideation	☐ Present	☐ 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**

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

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