Psychiatric Hospital Inpatient Admission Form

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I. Identifying information:	Medicaid #:	Date: / /	
Last name:	First name:	Middle initial:	
Date of birth: / /	Age: Sex:	Date of admission: / /	**Time:**
Facility name:		Provider #:	Name of contact person:
Commitment Type: *(if applicable)*	Effective Date:	County:	Judge:
Referral source: [ ] Admitting MD [ ] MH Professional [ ] DPRS [ ] Other (list):			
Current living arrangements: [ ] With parent(s) [ ] Group/foster home [ ] Other (list):			

IIA. Primary symptom described in "specific observable behavior" that requires acute hospital care:
(Include: Precipitating events leading to admission)

IIB. Other relevant clinical information, including inability to benefit from less restrictive setting:
(Attach additional pages or documents, as necessary)

IIC. Psychiatric medications (Include total daily dose)	**IID. Present and past drug/alcohol usage:**	
	Name of chemical	Current use?

IIE. Past psychiatric treatment

1. Number of previous inpatient admissions: [ ]	Dates of most recent inpatient stay: / / to / /
2. Previous ambulatory/outpatient treatment (provider or facility, frequency) – If none, why:	

III. Admitting diagnosis (Axis I):

IV. Additional diagnosis (Axis I and Axis II):

V. Functional assessment scores (DSM IV): GAF [ ]

VI. No. of hospital days requested: [ ] Dates: / / to / /

Projected discharge date (required): / /

VII. Aftercare Plan:

Provider or Facility:

Frequency:

Signature (Attending MD):		Date: / /
Print name:	Provider number:	Provider license number: