Facility Medical Record #: _____ **Admitting State Hospital/ADATC:** _____
Last 4 of SSN: _____ **DATE:** _____ **TIME:** _____

NC DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES

Regional Referral Form for Admission to a State Psychiatric Hospital or ADATC

Referral to: ☐ **Regional Psychiatric Hospital** ☐ **ADATC**
Referral made by: ☐ **Provider** ☐ **LME** ☐ **Self-Referral** ☐ **Other:**_____
Name of Referral Source/Agency:_____ **Contact #:(___)**_____
Consumer/Patient's Name:_____ Date of Birth:
_____
Last First Middle/Maiden MM DD YY
Other Names Used by Consumer (if applicable): _____ Gender: ☐ Male ☐ Female
Legal Guardian/Parent Name:_____ Relationship of Guardian to Consumer:_____
Consumer/Parent/Guardian Address:_____ Phone :( )_____
Consumer's Ethnicity: _____ Consumer's Contact Number(s): Home :( )_____ Work :( )_____
Consumer's County of Residence:_____
Type of Admission:
☐ Voluntary ☐ MI ☐ SA
☐ Involuntary ☐ MI/SA
Is Consumer Currently: ☐ Suicidal ☐ Homicidal
Describe (attempts, thoughts, plans):_____
_____
Mental Status (appearance/affect/behavior/hallucinations):_____
_____
Current Withdrawal Symptoms :_____
_____

SUBSTANCE USE INFORMATION: PLEASE COMPLETE FOR ALL INDIVIDUALS SUSPECTED OF SA USAGE

Drug of Choice Priority #
Major Substances Used
Route *
Frequency**
Date Last Used
Average Amount Used

***Route Codes:** 1=Oral 2=Smoking 3=Inhalation 4=Injection 5=Other 9=Unknown

****Frequency Codes:**
0=Drug not used during past month
1=Drug used 1-3 times in past month
2=Drug used 1-2 times in past week
3=Drug used 3-6 times per week
4=Drug used daily

ASAM PPC-2R CRITERIA: <u>FOR USE WITH ADATC REFERRALS</u>
Please select the appropriate level:

Level II – INTENSIVE OUTPATIENT / PARTIAL HOSPITILIZATION SERVICES

- ☐ **II.1** – Intensive Outpatient (more than 9 hours weekly)
- ☐ **II.5** – Partial Hospitalization (20 or more hours weekly)

Level III – RESIDENTIAL / INPATIENT SERVICES

- ☐ **III.3** – Clinically-Managed, medium intensity Residential Treatment (Extended Care, therapeutic rehabilitation facility)
- ☐ **III.5** – Clinically-Managed, medium/high intensity Residential Treatment (Therapeutic Community, intensive structured treatment with ancillary services)
- ☐ **III.7** – Medically-Monitored Intensive Inpatient Treatment (ADATC – sub-acute, transitional services)
- ☐ **III.9** – Medically Supervised Detox/Crisis Stabilization (ADATC – acute care hospital. Up to level IV behaviorally and level III.7 or below medically)

**** Lack of availability of appropriate, criteria-selected care and/or failure of a patient to progress at *<u>any</u>* given level of care may override the patient-treatment match with regard to levels of service.**

CONSUMER'S/PATIENT'S NAME:_____

<u>FEMALE ADATC REFERRAL</u>: ***CHECK ALL THAT APPLY***
ADATC Perinatal Referrals Do Not Require LME Authorization

☐ Individual is pregnant: ☐ Yes, # weeks _____ ☐ No ☐ Unknown **If yes, include ALL prenatal care information**
☐ Individual has child(ren): ☐ Yes ☐ No If yes, Age(s)_____

Side Effects to Medications: _____
Allergies: _____
History of Compliance with Medications:
_____
Time Vital Signs Taken:_____ BP:_____ Pulse:_____ Resp:_____ Temp:_____ Weight:_____
BAC: _____ Time: _____
Labs Completed: _____
Fax applicable lab work along with referral form

Axis I: _____
Axis II: _____ ***Follow SB859 procedures for MR/DD referrals***
Axis III: _____
Axis IV:_____
Axis V: _____

PCP Available: ☐ Yes ☐ No ***If Yes, Please Attach*** ***If PCP is not available attach current treatment plan and/or crisis plan***
Previous Medical/Psychiatric/SA Admission(s) to Any Hospital/Facility in the past 3 months (where, when, why):
_____
_____

Other Treatment Used Prior to Referral to Hospital: _____
_____

Reason(s) that Other Treatment Efforts were not Successful: _____
_____

Medical History: ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Seizure Disorder ☐ Pregnant ☐ Ambulatory
☐ Hepatitis ☐ Chronic Pain ☐ Recent Trauma ☐ Recent Seizure ☐ Asthma ☐ Other _____
Comments: _____

Current Psychiatric Medications/Injections: **Current Medical Medications/Injections:**

Pending Legal Charges: ☐ Yes ☐ No ☐ Detainer (County)_____ Court Order ☐ Yes ☐ No
☐ Unknown Description:_____ Court Order Attached ☐
☐ House Bill 95 (ITP) ☐ Senate Bill 43 (NGRI)
Consumer Adjudicated Incompetent: ☐ Yes ☐ No ***If yes, attach copy of documentation if available***
Is Consumer a Minor? ☐ Yes ☐ No Name of Responsible Parent/Adult/Guardian:_____

CONSUMER'S/PATIENT'S NAME:_____

Goal of Hospitalization: _____
Treatment Objectives (Including specific suggestions for treatment planning):
_____
_____

Proposed Discharge Plans: _____

_____

Placement Considerations: _____

_____

Identified Additional Social Supports/Resources:

Name:	Address	Phone #	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional Contact Information:

Clinical Home Provider Agency:_____ Phone: ( )_____ Fax: ( )_____

Agency After Hours :_____ Phone: ( )_____ Fax: ( )_____

LME Contact: _____ Phone: ( )_____ Fax: ( )_____

(*Hospital Liaison/Care Coordinator//Other LME Representative*)

Assigned Psychiatrist:_____ Phone: ( )_____ Fax: ( )_____

Community Support Provider:_____ Phone: ( )_____ Fax: ( )_____

Other Provider: _____ Phone: ( )_____ Fax: ( )_____

Third Party Coverage: Medicaid #: _____ Medicare #: _____ Other: _____

Insurance Co.: _____ Policy Holder: _____ Policy Number: _____

Attach copy of insurance card if available

If Insurance: Hospitals Contacted:

1)_____

Form completed by:_____ **2)** _____

Signature **3)**_____

_____ _____

Title Date

AUTHORIZATION BY THE LME: PRTF REFERRALS DO NOT REQUIRE AUTHORIZATION

Referring **County:_____ Phone#:_____**

Authorization #:_____ From:_____ To*:_____

Hospital Beds	**ADATC Bed**
☐ Adult Admissions	☐ **Acute**
☐ Adults Long-Term	☐ **Sub-Acute**
☐ Geriatric Admissions	
☐ Adolescent Admissions	* Day Not Covered
☐ Child Admissions	

Responsible **County:_____Phone #:_____**

Authorization #:_____ From:_____ To*:_____

Hospital Beds	**ADATC Bed**
☐ Adult Admissions	☐ **Acute**
☐ Adults Long-Term	☐ **Sub-Acute**
☐ Geriatric Admissions	
☐ Adolescents/Child Admissions	* Day Not Covered
☐ Child Admissions	

FOR STATE FACILITY USE ONLY – IF NO AUTHORIZATION INFORMATION IS PROVIDED BY THE LME:

Referring **County:_____ Phone#:_____**

Hospital Staff Making Phone Call:_____

☐ No Response Within 1 Hour of Call

If Response – Person Authorizing Days:_____

Responsible **County:_____Phone #:_____**

Hospital Staff Making Phone Call:_____

☐ No Response Within 1 Hour of Call

If Response – Person Authorizing Days:_____

PLEASE NOTE:

ANY MISSING INFORMATION MUST BE SENT TO THE ADMITTING FACILITY WITHIN ONE WORKING DAY OF

THE CONSUMER'S ADMISSION. GUARDIANSHIP PAPERS MUST BE FORWARDED WITHIN ONE WORKING DAY OF ADMISSION.