Bullock County Hospital
Gateway's Acute Psychiatric Services
Referral Form

Referring Professional:
*Agency / Professional:*____

*Contact Numbers:*_______________________________________*Location:*__________________________

Patient/ Client Information:

Name:____ **Date of Birth**________________________

Address:____

Phone Number(s):____ **Gender**________ **Race**_____________

Marital Status______________________________ **Social Security Number:**_________________________

Emergency Contact/Relationship/Phone:____

Employed, Unemployed or Disabled___________ **Employer/Occupation**________________________

Primary Insurance:____

____

Secondary Insurance:____
Please include Group Name/Employer, ID#, Group#, Name of Insured, Relationship to Insured, Phone #, IRF-PIA Code
Presenting Problem or Compliant including date of onset:____
____
____
____
____
____
____
____

Diagnosis by History and/or Current Impression:______________________________________
Previous Hospitalizations/Treatment:____

Will the patient/client be Court Ordered if approved for admission?_______________
Current Medications:____
____
__

Is patient/client medically stable?____

Is patient/client experiencing symptoms of psychosis? If so, please describe:

Is patient/client experiencing symptoms of a mood disorder? If so, please describe:

Are there thoughts of harm to self or others? If so, please describe including any plans, intent or gestures:

Please indicate whether patient/client is currently experiencing any of following:

__Increased Sleep __Decreased Sleep __ Interrupted Sleep __Anxiety

__ Increased Appetite __ Decreased Appetite __Weight Gain __ Weight Loss

__Hallucinations *describe:*

__Paranoia *describe:*

__Delusions *describe:*

__ Feelings of worthlessness, helplessness, hopelessness or guilt *describe:*

__Anhedonia __Difficulty performing ADL's

__Mania or Expansive Mood *describe:*

__ Changes in Thought Processes or Thought Content *describe:*

__ Problems with medication or Extra Pyramidal Side Effects *describe:*

__History of regular substance use/abuse or addiction *describe:*

__Cognitive Disability *describe:*

__Mental Status Change *describe:*

Medication Management Concerns or Request:

Allergies:

Requests regarding discharge planning:

Medical History:

Additional Information:

Additional Information Required:

***Referrals from Hospitals*-Triage Sheet, History and Physical, Labs-UA, UDS, CBC, Chem 7, Vital Signs, ETOH, Chest X-ray, EKG, Emergency Contact Information, Discharge Plans/Placement**

***Referrals from Nursing Homes*- Letter of Agreement for patient to return to Nursing Home once stabilized, Doctor's Orders, Progress Notes, Current Meds and Treatment**

***Referrals from a Mental Health Agency*-Counselor's or Psychiatrist's recent notes if available, Emergency Contact Information, Most Recent Assessment, and Current Medications**

General Requirements for admission:

1. The patient must be 19 years of age.
2. The patient must have a provisional DSM-IV TR Axis 1 psychiatric diagnosis.
3. The patient must be medically stable and able to participate in the psychosocial programming of unit. *Patients who are medically ill, bedfast or delirious are not appropriate for unit.*
4. The patient must meet a least one of the following:

Inappropriate performance of activities of daily living as evidenced by:

- Inappropriate hygiene
- Psychomotor agitation or retardation

Impaired safety as evidenced by:

- Inappropriate, depressed agitated mood
- Suicidal ideation, threat, gesture or attempt

Impaired thought process as evidenced by:

- Verbal or behavioral disorganization
- Thought disorganization, hallucinations, paranoid ideation, phobias, etc.
- Impaired reality testing
- Bizarre or delusional behavior
- Disorientation or memory impairment to the degree of endangering the patient's welfare
- Severe Withdrawal or Catatonia

Inpatient treatment required due to:

- Failure of outpatient therapy
- Failure of social or family function which places patient at risk
- Treatment in a less restrictive environment not feasible due to patients behaviors

The patient needs inpatient evaluation:

- Need for 24-hour skilled nursing and intensive observation
- Recurrence of psychosis not responding to outpatient treatment
- Toxic effects from therapeutic psychotropic drugs

Evaluation Outcome:

___**Accepted for Inpatient Admission** __**Recommend OP Services**
__**Recommend Medical Inpatient** __**Specific Non-admit Reason**

Disclosure Statement Discussed: ___**Yes** ___ **No**
Guardian Agrees to Admission: ___**Yes** ___**No**

Bed Available: ___**Yes** ___**No**
Order Received__________________ **Anticipated Admission Date**________

Communication Notes:
Date/Time Note: (Summary of all communication with Medical Director to include the process of obtaining an order to admit)

_________ ____

_________ ____

_________ ____

_________ ____

_________ Patient not appropriate for admission at this time

_________ Patient needs to be admitted at this time for an aggressive, multidisciplinary course of therapy and daily medications managed in an acute setting to safely and effectively manage his/her rehabilitation needs and co-morbid conditions.

Provisional Diagnosis at Admission:____

____

____ _______________
Medical Director Date

____ _______________

Intake Coordinator Date

____ _______________

Nurse Manager or Registered Nurse Date