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Please check which program(s) the individual is being referred to:

23-Hour Observation and Holding

Siouxland Mental Health Crisis Center

Subacute

Siouxland Mental Health Crisis Center

Crisis Stabilization Residential Services - Adult

- Turning Point – Plains Area Mental Health Center
- Siouxland Mental Health Crisis Center
- Alex’s Place - Seasons Center for Behavioral Health

Crisis Stabilization Community- Based Services – All Ages

- Plains Area Mental Health Center
- Siouxland Mental Health Crisis Center
- Seasons Center for Behavioral Health

Dependent upon the location, at least one of the following criteria may prohibit the individual from admittance:

- Acute medical condition – Note: individual may be monitored and screened for later acceptance of admission.
- Inability to complete activities of daily living by self (toileting, showering, dressing, grooming, etc.)
- Sex offender
- High risk behavior of violence
- Over the legal alcohol limit; may admit after a lab test showing under the legal limit.
- Currently detoxing due to alcohol

Referral Information

Name: _____ Preferred name: _____
 DOB: _____ SSN#: _____ PH: _____
 Address: _____ County: _____
 Legal Guardian or Power of Attorney? Yes ___ No ___ If Yes, Who: _____
 Emergency Contact Name & PH: _____
 MCO/Medicaid #: _____ Other Insurance: _____

Sex: _____ Sexual Orientation: _____ Gender Identity: _____

Preferred Pronouns: _____ Race: _____ Military Y/N: _____ Marital Status: _____

Religious preference and needs (food, routines, etc.):

Check all the following behaviors that apply:

- Manic Behavior Threatening Others Paranoia
 Borderline Traits Auditory Hallucination Aggressive Behavior
 Visual Hallucinations Depression Anxiety
 Self-Harm Isolated or Withdrawn Sexual Problems
 Current and/or History of Eating Disorder Current and/or History of Pica

Please describe impairments that are occurring due to mental health symptoms: _____

History

Mental Health Illness: Yes No If yes, List Diagnosis: _____

Currently receiving outpatient psychiatric treatment?

Yes No If yes, Name of Provider & Agency: _____

Currently have a Case Manager, Integrated Health Home worker, or DHS case worker?

Yes No If yes, Name of Worker & Location: _____

Please attach a list all prescribed and over-the-counter medication the individual is currently taking. Include recently stopped medications.

Name of Current Pharmacy: _____

SUBSTANCE USE SCREENING: *Please ask the individual the following.*

<u>The last time they used in the past month</u>	Not at all	1-3 days	3 days or more
Any type of alcohol (beer, liquor, wine)			
Marijuana			
Methamphetamines			
Cocaine			
Heroin			
Ecstasy			
Inhalants (fluids, gasoline, lighters, paint)			
Prescription drug abuse (Xanax, OxyCotin, Vicodin, Codeine)			
OTC medication abuse			

Discharge Planning:

List any pertinent medical information, discharge planning, support system, follow-up information: _____

Provide the following list of clinical information:

- History & Physical or most recent Primary Care Physician Note, if applicable
- Psychiatric Evaluation and supporting documentation, if applicable

The purpose of this referral has been explained to me and I voluntarily choose to participate.

Individual Signature: _____ Date: _____

I have reviewed the material, and it is my professional opinion that the individual is appropriate for a lower level of care than inpatient behavioral health.

Referring Provider & Agency Signature: _____ Date: _____

Print Name: _____