Referral Information

Date Sent to Permedion:	
Hospital/Facility Name:	
Contact Person:	
Email address:	
Phone:	
City, State	
Date of Admission:	
Admission source:	
Involuntary admission:	☐ Yes ☐ No

Recipient Information

Last Name:	**First Name:**
Medicaid ID:	SSN:
Gender: ☐ **Male** ☐ **Female**	**DOB:** **Age:**

Marital Status:	☐ Single	☐ Married	☐ Divorced
	☐ Widowed	☐ Other: (explain)	
Living Arrangements:	☐ Alone	☐ Court Ordered	☐ Group Home/Half-Way House
	☐ Homeless/ Shelter	☐ Non-Relatives	☐ Foster Home
	☐ Relatives	☐ Nursing Home	☐ Assisted/Supervised
	☐ Parents/Guardian	☐ Spouse/Significant Other	☐ Other:(explain)
City, State			

Responsible Party Information

Responsible Party (Last Name, First Name)			
County:			
Relationship:	☐ Self	☐ Parent(s)/Guardian	☐ Court
	☐ Gov. Agency	☐ Other: (explain)	
☐ **Address same as recipient**			
City, State			

Mental Health Diagnoses

	Diagnosis	DSM5	ICD-10
Provide all Diagnoses			

Medical Diagnoses

Psychosocial and Environmental Factors

Mark "X" and describe.

	Problems with primary support group	
	Problems related to social environment	
	Educational problems	
	Occupational problems	
	Housing problems	
	Economic problems	
	Problems with access to Health Care Services	
	Problems related to interaction with legal system	
	Other psychosocial and environmental problems	

Mental Status Symptoms

Mark "X" and describe.

	Auditory hallucinations	
	Visual hallucinations	
	Delusions	
	Paranoia	
	Bizarre thinking	
	Thought content	
	Anxiety level	
	Appearance	
	Mood	
	Affect	
	Behavior	
	Dementia	
	Delirium (Acute onset < 48 hour)	
	Speech	
	Cognition	
	Insight/Judgment	
	Sleep	
	Hygiene	
	Nutrition	

Harm to self: Mark "X" and describe.

	Actual recent suicide attempt/serious self-harm.
	Current threat/plan/intent of suicide/serious self-harm.
	Current command hallucinations of suicide/serious self-harm

Harm to others: Mark "X" and describe.

	Actual recent harm to others
	Current threats/ plan to harm others
	Current command hallucinations to harm others

Mental Status Symptoms cont.

If patient is unable to care for self, explain how and to what extent.

Current Medication Information

List all current medications.

Drug Name	Dose/Route	Frequency	Started	Compliant yes/no?

List historic psychotropic medications.

Drug Name	Dose	Started	Ended	Reason for DC

Substance Abuse/ Current and Historical

Complete all applicable rows.

	Drug Substance/name	Frequency	Amount	Route	1st Use	Last Use
Alcohol						
Cannabis						
Hallucinogens						
Benzodiazepines						
Inhalants						
Amphetamines						
Barbiturates						
Narcotics						
OTC Meds						
Other						

****Provide toxicology screen results.**

Has substance abuse impacted treatment compliance? Explain how.

Prior Outpatient/Community Treatment

Identify all prior mental health interventions and services.

Agency/Facility Name	Type of Service	Dates of Service	Frequency of Service (Hours/day)

Legal

Is inpatient treatment court ordered? ☐ Yes ☐ No
If "Yes", for what purpose? ☐ Evaluation ☐ Return to Competency
What county issued court order?

Mark "X" and describe.

☐	Current Legal charges	
☐	Pending court date(s)	
☐	Currently on probation/parole	
☐	Past legal issues	
☐	Current/History of domestic violence	
☐	Physically destructive acts/property destruction	

Trauma and Abuse

Mark "X" and describe.

☐ Recent Trauma/ Abuse:

☐ Past Trauma/ Abuse:

Additional Information:

Inpatient Psychiatric Treatment History

Prior Inpatient Treatment?	☐ No	☐ Yes
Readmission within the past 30 days?	☐ No	☐ Yes
Age at first admission:		

Please complete for each admission:

Month	Year	Facility	Length of Stay

Children & Adolescents Only (Under 21)					
Mark "X" and describe.					
	CON completed and signed by a physician, and on the medical record.		Yes		No
	Children's Services involvement				
	Other Information				

Geriatric Patients Only (65 years and older)		
Mark "X" and describe.		
	Patient is a transfer from another unit (such as medical).	

Additional Information
Describe precipitating events, and presenting symptoms, that necessitated treatment and subsequent inpatient admission.
Any additional pertinent information to support the medical necessity for admission.

Attestation/Signature	
I affirm all information is a true and accurate description of the above individual.	
Completed by:	
Date:	