



RESIDENTIAL CRISIS SERVICES OF
 GARRETT COUNTY LIGHTHOUSE, INC.
 P.O. BOX 116
 OAKLAND, MD 21550
 Lighthouse: (301) 334-9126/ Fax: (301) 334-8894
 Safe Harbor: (301) 334-1642/ Fax: (301) 750-7307
 Compass House: (240) 362-7082/ Fax: (240) 362-7085

**Referral for Residential Crisis Services
 Inpatient Admission Prevention Level of Care
 ALL INFORMATION ON REFERRAL IS REQUIRED AND MUST BE COMPLETED**

Name: _____ Date: _____

Address: _____
 _____ Telephone: _____

Date of Birth _____ Social Security # _____ Gender _____ Race _____

Education: _____ Below 12th grade _____ GED _____ High School Diploma _____ College _____

Employment: _____

Emergency Contact: _____ Telephone: _____

Current living arrangement: _____

Marital Status: _____ Dependent Children: _____ # in Family: _____

SSI _____ SSDI _____ Food Stamps _____

Other Income: _____ Fee Basis: _____ Yes _____ No _____

Veteran: _____ Yes _____ No _____ VA income _____ VA Medical Benefits _____

Medical Assistance # _____ Medicare # _____

QMB: _____ Yes _____ No _____

Other Medical Insurance: _____ Policy # _____

Other Payment Sources: _____

A. Eligibility Screening (All must apply)

COMAR 10.21.26.04.B1

- _____ requires inpatient admission prevention level of care not admission alternative
- _____ for clinical reasons, requires a temporary separation from current living situation
- _____ patient understands and has stated willingness to comply with RCS rules expecting supervision
- _____ will be able to care for physical and personal needs with support

OTHER REQUIRED CRITERIA

- _____ patient is NOT in need of immediate involuntary inpatient psychiatric hospitalization
- _____ patient is NOT a danger to self or others
- _____ patient has NOT voiced being intoxicated by drugs or alcohol, or under the influence in the last 24 hrs.
- _____ patient has NOT been declared medically unstable
- _____ patient is NOT taking new or altered dosages of medications that results of which are yet unknown
- _____ patient has been asked about potentially dangerous items in their belongings
- _____ patient is free and/or fully treated against any visual human infestations.

Referral Source: _____

B. Diagnostic Information: (BE SURE TO INCLUDE F CODE PLEASE)

Diagnosed by: _____ Date of diagnosis _____

Drug abuse: _____ Alcohol abuse: _____

Developmental Disability: _____

Other Physical Impairment: _____

Presenting Problems: _____

C. Health Services

Has the patient had previous psychiatric hospitalizations? _____ Yes _____ No

Place of last hospitalization: _____

Other relevant history: _____

Psychiatrist:

Name: _____

Address: _____

Phone: _____

Therapist:

Name: _____

Address: _____

Phone: _____

Psychiatric medication monitoring: _____ Yes _____ No

Is patient being discharged with 14 days of necessary medications: _____ Yes _____ No

Patient has a history of medication non-compliance ___ Yes ___ No

Patient agrees that ALL medications including rescue inhalers are not permitted to be carried freely ___ Yes ___ No

Medication

Dosage

Frequency

Please comment or indicate if this is a change in medication from the patient's previous regimen:

Somatic Care Physician:

Name: _____

Address: _____

Phone: _____

Please indicate or comment on any relevant medical/somatic history including assessment of general physical health (illness, physical disabilities, allergies):

D. Rehabilitation Services

Is the patient currently involved in a structured day program? _____ Yes _____ No

Name of program: _____

Contact person: _____

Recommended rehabilitation and/or treatment goals: _____

Patient discharge plan following 10 day crisis stay: _____

E. Authorization for Services

ASO Care Manager (full name): _____

Initial level of care approved (please mark):

BOTH NEED REQUESTED WHEN OBTAINING AUTHORIZATION

_____ T2048 Residential room and board

_____ S9485 Residential crisis services

1:4 staff to client ratio coverage acceptable for patient needs _____ Yes _____ No

Clinical Rationale: _____

Date Range _____ to _____ Authorization # _____

Other insurance authorization information (if applicable):

F. Signatures

Physical health assessed by ER physician/somatic physician: _____ Yes _____ No

If yes, ER physician/somatic physician name and credentials: _____ Date: _____

Face to face evaluation occurred as part of the referral: _____ Yes _____ No

If no, patient gives consent to participate in a face to face evaluation within 24hrs of discharge. ___Yes ___No

Referring source understands that a patient discharged for violation of rules or behaviors presenting a risk to self, staff, or others and may require emergency care. Secondary level of care or discharges lasting longer than 24hrs will require the submission of a new referral and assessment. _____ Yes _____ No

Signature of referring Mental Health Professional / Physician Date: _____

Printed name and credentials required

Following only to be completed by psychiatrist or appropriately privileged mental health professional: (COMAR 10.21.26.05.B1)

I have assessed the physical health of this patient: _____ Yes _____ No

Need of physical exam or somatic follow up: _____ Yes _____ No

Face to face evaluation by psychiatrist: _____ Yes _____ No

Mental Status Examination/Screening Assessment:

Signature of Psychiatrist Date: _____

Printed name and credentials

IF PHYSICAL HEALTH HAS NOT BEEN ASSESSED BY A MEDICAL PROFESSIONAL SOMATIC APPOINTMENT WILL NEED TO BE SCHEDULED FOR ASAP AFTER ADMISSION TO RESIDENTIAL CRISIS SERVICES FACILITY.