RESIDENTIAL CRISIS SERVICES OF
GARRETT COUNTY LIGHTHOUSE, INC.
P.O. BOX 116
OAKLAND, MD 21550
Lighthouse: (301) 334-9126/ Fax: (301) 240-387-6978
Safe Harbor: (301) 334-1642, safeharbor@gclighthouse.org

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

____ Date:_____________

Signature of referring Mental Health Professional / Physician

____

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:

____

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____

____ Date: ____________________

Signature of Psychiatrist

____

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.