



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  
 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**

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Gender \_\_\_\_\_ Race \_\_\_\_\_

Education: \_\_\_\_\_ Below 12<sup>th</sup> 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)**

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Diagnosed by: \_\_\_\_\_ Date of diagnosis \_\_\_\_\_

Drug abuse: \_\_\_\_\_ Alcohol abuse: \_\_\_\_\_

Developmental Disability: \_\_\_\_\_

Other Physical Impairment: \_\_\_\_\_

Presenting Problems: \_\_\_\_\_

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**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

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

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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):

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**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: \_\_\_\_\_

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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):

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**F. Signatures**

Physical health assessed by ER physician/somatic physician: \_\_\_\_\_ Yes \_\_\_\_\_ No

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.