Pathways Center for Behavioral and Developmental Growth
CSP Referral/Outpatient Crisis Intervention Form

Referring to:
☐Second Seasons (2013/ 1013 / Affidavit)
☐Hopes Corner (2013/ 1013 / Affidavit)
☐**Other:** ___________________________

Is consumer active in Pathways? ☐Yes ☐No

Community Authorization:
Single Point of Entry (SPOE) Provider Use only:
Region:________ SPOE Provider: ______________
Staff:___________________Date:_______Time:_____

☐Met Criteria for Hospital or CSP Referral
(circle which one)
☐Did **NOT** meet criteria for Hospital Referral/CSP
Comments:

HIPPA Code **(Completed by Pathways Center Staff only):**			**Units:**
Date:	Referring Facility:	Type of Facility:	
Staff Making Referral:		Advocate:	Phone:
Legal Commitment Document	Hold Order ☐Yes ☐No	Jail Referral ☐Yes ☐No Forensic Referral ☐Yes ☐No	Youth Detention Center (YDC) ☐Yes ☐No
	Source of Hold Order	Charges	Regional Youth Detention Center (RYDC)☐Yes ☐No

Identifying Information

Consumer Last Name:	First:	Middle:	Maiden:
Consumer Aliases:			
Sex:	Race:	DOB:	SSN:
Address:	City:	State:	Zip:
Phone Number:	County of Residence:	County of Commitment:	
Insurance	☐Medicaid #	☐Medicare #	
☐Private	☐Number	☐Non-Insured	
Religion:	Primary Language:	Language Barrier:	
Legal Guardian Name:	Relationship:	Phone:	
Legal Guardian Address: *(if different from consumer)*			
DFCS Representative Name:	County:	Phone:	
Emergency Contact Name:	Relationship:	Phone:	

Current Living Situation: ☐Homeless ☐Shelter ☐w/family ☐w/Friends ☐Independent Living
☐Personal Care Home ☐Group Home ☐**Medicaid Waiver Home**

SPECIAL ALERT RISK: ☐ AWOL Risk ☐Sexually Assaultive ☐Physically Aggressive ☐DT's Risk

Does the consumer have a Mental Retardation Diagnosis? ☐Yes ☐No
If Yes, ☐Mild ☐Moderate ☐Profound ☐Severe ☐Unspecified

Does the consumer have a Mental Illness Diagnosis? ☐Yes ☐No
If **Yes**, Code: Diagnostic Impression:

Treatment Facility/Provider:

Reason for the Referral (Describe the presenting problem/cause and onset)

Reporting Problems

Hallucinations	**Violent/Dangerous Behaviors**	**Alcohol & Drug Use (Send UDS if possible)**
☐Auditory	☐Suicidal Threats/Gestures	☐Alcohol Abuse/Dependence
☐Visual	☐Homicidal threats/Gestures	☐Drug Abuse/Dependence
☐Tactile	☐Destructive Behavior	☐Intoxicated
☐Gustatory	☐Confused Behavior	☐Need Detoxification
☐Olfactory	☐Self-Injurious Behavior	☐In Withdrawal
☐Command		☐Blood Alcohol Level
	Other	☐Elevated Vital Signs
	☐Mania	☐History of DTs
	☐Delusions	☐History of Blackouts
		☐ History of Seizures

Vital Signs					
Allergies:					
B/P:	Pulse:	Respiration:	Temperature:	Height:	Weight:
If vital signs are not obtained, provide explanation:					
Does the consumer have any Medical/Physical problems or Limitation? ☐Yes ☐No *(If Yes, please explain)*					
If seizures are they alcohol or Drug Related? ☐Yes ☐No					
Is consumer PREGNANT? ☐Yes ☐No ☐Unknown If **Yes**, Length of pregnancy_______ Date of last prenatal visit__________					
Needs Assistance with wheelchair or ambulation? ☐Yes ☐No Needs Rehabilitative services or more permanent Placement? ☐Yes ☐No					

List current medications taken in the last week *(or fax medication log)*:

Name	Amount	Frequency	Last Taken

Alcohol and Drug Use/ ABUSE

Name	Amount	Frequency	Last Taken	Name	Amount	Frequency	Last Taken
Alcohol				Crack/Cocaine			
Marijuana				Methadone			
Stimulants				Inhalants			
Heroin				Other			

If the answer to any of the following questions is yes, usually the consumer is inappropriate for the level of care at a MHDDAD Regional Hospital or Second Season. The consumer will require further evaluation and discussion.

Does the consumer….?	Yes	No	If Yes, Explain
1. Require highly specialized medical services, dialysis, or high acuity nursing care?			
2. Require IV Fluids, IV antibiotics, or hyperalimentation?			
3. Require further evaluation of acute care of chest pain, hypertension, or diabetes?			
4. Have a diagnosis of delirium or altered level of consciousness?			
5. Have an indwelling urinary or other catheter?			
6. Have a primary diagnosis of dementia (including Alzheimer's disease)?			
7. Have infections/contagious diseases (e.g. TB, measles, MRSA, etc.) or wound requiring isolation or procedures to prevent transmission?			
8. Have a behavioral condition secondary to traumatic brain injury, which may have related organic, physical, or social disorders? (OCGA Section 37-3-1: "traumatic brain injury shall not be considered mental illness")			
9. Require continuous administration of oxygen?			
10. Have an acute overdose and may be medically unstable?			
11. Has the consumer been evaluated to determine the need for medication to reduce anxiety or agitation prior to transportation?			

THE HOSPITAL IS NOT APPROVED AS A MEDICAID PROVIDER FOR INPATIENT PSYCHIATRIC SERVICES

SPECIAL INSTRUCTIONS

* Please fax labs and/or drug screens, if available

* **Forensic Court Ordered referrals** require authorization by Forensic Services and completion of the *High Risk Form*.
Second Seasons will NOT accept Forensic Court Ordered Referrals

* Referrals from jails, prisons, youth detention centers, court systems, and other criminal justice systems require completion of the *High Risk Form*.

* **All criminal/court order requests** must be received in written communication before approval for transport.

*All legal commitment documents must be completed correctly and faxed before approval for transport. The original legal commitment documents must accompany consumer at the time of transport.

Initial Crisis Plan and Recommended Follow-Up: ____

____

Consumer Survey: Was this service helpful in deescalating the crisis for the consumer? ☐Yes ☐No

Staff Signature ____ Date ____________________

HIGH RISK / NON-STANDARD ADMISSION FORM

This form must be completed when: (Check which applies)

- ☐ Any forensic or hold patient is being admitted/transferred to a unit other than a secure unit
- ☐ A high risk forensic or hold patient is being admitted to a secure unit at a regional facility

---

Definition of high risk: The patient meets one of more of the following conditions: (1) poses a significant risk of escape while in a DHR facility; (2) has a high profile case or one that attracted media attention; and/or (3) is charged with a crime that involved potential or actual significant harm to another.

Identifying Information

Date: ____________________ Time:________________ ☐AM ☐PM Hospital/CSP: ____________________

Name: ____________________________________ SSN# ____

Count Jail/Detention Center: ____

Reason for Admission: ____

____

Information from Law Enforcement

Charge(s): ____

Describe briefly what the patient is alleged to have done to get these charges: _______________________________

____

____

Describe any injuries or threats to others during alleged offense: ________________________________

____

____

Weapons used/present: ☐Yes ☐No, If yes what type: ____

History of escape attempts (from custody, jail or prison): ☐Yes ☐No

Describe any continued risk to victims: ____

____

Describe individual's behavior while in law enforcement custody: _________________________________

____

____

____

____

ADDITIONAL INFORMATION CONSIDERED (e.g. patient is known to hospital staff, previous attempts/elopement form hospital, age/physical condition; or any other circumstances that might increase or decrease risk). _________

____

____

____

____

____

____

____

____

____