The following items are required to process the referral for CABHH. We request that the process of collecting the documents begin immediately by the County Case Manager or holding facility at time of referral.

Please send the completed referral form and accompanying documents to Central Pre-Admissions (CPA) via email to dhs.sos.centralpreadmissions@state.mn.us or fax to 651-431-7705 or 866-633-4253.

If you have any additional questions while filling out this form, please call CPA at 651-431-5337 or 866-966-2337.

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| **MEDICAL PAPERWORK** |
| [ ]  ROI’s (**TO and FROM** CCM, Inpatient Facility, Outpatient Psychiatrist, Therapists, Primary Physician, all other team members)[ ]  Diagnostic Assessment (most recent)[ ]  IEP Evaluation[ ]  Neuropsych Testing**From the current location:**[ ]  Demographic Face Sheet[ ]  History and Physical (or recent annual physical)[ ]  Psychiatric Assessment[ ]  Social Work Assessment[ ]  Medical Consults[ ]  Labs (most recent)[ ]  Current MAR (Medication Administration Record)[ ]  Last 7 Days of Progress Notes[ ]  If in jail, any medical and behavioral information available including behavioral logs and incident reports |

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| --- |
| **LEGAL PAPERWORK** |
| [ ]  Decision Maker Order *(****All* *legal document****s indicating who is responsible for the child, i.e., Guardianship Order, Adoption Decree, Divorce Decree, Custody Order, Termination of Parental Rights Order, Delegation of Parental Authority, Guardian Ad Litem Order, Substitute Decision Maker Order, etc.)***If Civilly Committed or Pending Civil Commitment:**[ ]  Pre-Petition Screening Report[ ]  Petition for Commitment[ ]  Examiner’s Report[ ]  Order for Commitment[ ]  Order Revoking Provisional Discharge (if applicable)[ ]  Jarvis/Price Sheppard Order (if applicable)**If there is a Rule 20 or Pending Rule 20:**[ ]  Criminal Complaint[ ]  Criminal Order indicating finding of incompetency[ ]  Rule 20 Evaluation Report |

Client Referral Information

Client Name:      Name

Preferred Name:      Name

Pronouns:      Name

Date of Birth: Click or tap to enter a date

County:

Present Location:

Are you seeking inpatient psychiatric hospitalization, residential care, or are you unsure of the level of care needed? *(Please note CABHH is an acute inpatient psychiatric hospital and NOT residential level of care)*

Brief Client History and Current Presentation (*Who, What, When, Where*):

Reason for Referral to CABHH *(What is the team looking for the pt. to get out of treatment at CABHH)*:

Is the team in agreement with the referral to CABHH?

Where will the client be discharging to after CABHH?

**PRESENT DIAGNOSIS:**

**CURRENT MEDICATIONS:**

**Does the client have insurance?** [ ]  No [ ]  Yes, Name:       ID/Policy Number:

**Brief Medical Screening Questions**

To the best of your abilities, please answer the following questions regarding medical needs for the individual being referred.

**Do they have any assistive devices?**

**-If so, what equipment is needed** *(i.e. CPAP, walker, wheelchair, crutches, etc.)***?**

**-Will the client bring the equipment with them upon admission?**

**-Will the hospital be writing an order for medical equipment needed for admission?**

**Any recent injury requiring nursing care?**

**Any current mobility Limitations?**

**Are they a fall risk?**

**Any current or history of ingestion or insertion of foreign objects?**

**Any dental Concerns?**

**Any withdrawal symptoms?**

**Are they insulin dependent?**

**Are they in need of treatment for medical conditions such as: Dialysis, Seizure disorders, Bleeding disorders, HIV, Cancer therapy, Orthopedic, Surgical issues?**

**Any other special needs** *(i.e. cognitive, dietary, cultural, religious, etc.)***?**

**Client Contact Information**

*Please include all available contact information.*

**Referred By:**

Name

Location

Email

Phone

Fax

**Client’s Present Location:**

Name

Location

Email

Phone

Fax

**Attending Psychiatrist:**

Name

Location

Email

Phone

Fax

**County Case Manager:**

Name

Location

Email

Phone

Fax

**Decision Maker:**

Name

Location

Email

Phone

Fax

**CPS Worker:**

Name

Location

Email

Phone

Fax

**Guardian:**

Name

Location

Email

Phone

Fax

**Guardian Ad Litem:**

Name

Location

Email

Phone

Fax

**Primary Care Physician:**

Name

Location

Email

Phone

Fax

**Outpatient Psychiatrist:**

Name

Location

Email

Phone

Fax

**Outpatient Therapist:**

Name

Location

Email

Phone

Fax

**Any Outpatient or In home Treatment Programs:**

Name

Location

Email

Phone

Fax

**School:**

Name

Location

Email

Phone

Fax