

**In an effort to streamline the referral process and complete referrals as efficiently as possible, please be aware of the following**:

* Completing the form thoroughly and sending the documentation as soon as possible will lend to timelier placement.
* The client being referred to CARE must meet the following admission criteria:
* The client is not in need of emergency care or care not provided by the program.
* The client is not in need of medical diagnostic evaluation or acute hospitalization.
* The client is not in need of acute drug or alcohol detoxification.
* The client does not pose an imminent likelihood of physical harm to self or others.
* The client is both psychiatrically and behaviorally stable and can participate in substance abuse treatment.
* The client must be independent with self-cares (i.e. dressing changes, transfer, toileting, etc.) and not need of rehab or Nursing Home care
* Please begin work on verifying that funding will be in place for a CARE admission at the time of initial referral to CARE. This will help prevent delays in admission.
* The following items are required **prior** to admission. CPA requests that the process of collecting them begin immediately by the County Case Manager or holding facility at time of referral. State-issued H&P and standing order forms are attached for reference.
1. **Written Prescriptions (not filled pill bottles)** – for a 30-day supply. Orders cannot be for 1-2 tabs; we need orders for a predetermined dose. All CARE sites have a contracted pharmacy, orders will be sent there for processing.
2. **History & Physical (H&P)** – may be signed by the MD, APRN, CNP, or a PA. *The H&P cannot be older than 30 days*.
3. **Standing Orders** – Can be signed by MD, APRN, CNP, PA
4. ALL funding must be in place prior to admission to C.A.R.E.

***Information received quickly will expedite placement. Incomplete H&P’s and Scripts will delay admission.***

|  |  |
| --- | --- |
| **Send at time of referral:**[ ]  Pre-Petition Screening[ ]  Order for Commitment[ ]  SUD/CD assessment (if completed and available)[ ]  CARE Referral Form[ ]  Guardianship papers *(if applicable)* | **Required prior to admission:**[ ]  Standing orders signed by a Licensed clinician[ ]  30 days of written prescriptions [ ]  Furlough order[ ]  Most recent Psychiatric discharge summary (if available) |
| **Records needed for admission approval:**[ ]  Medical History & Physical (Must be completed within 30 days of admission to CARE)[ ]  Current Medication Administration Record[ ]  Remainder of Commitment paperwork * Examiner’s Statement
* Initial Order
* Request to revoke
* Revocation Orders

[ ]  10 days of progress notes  | **Please provide Funding/insurance information:**[ ]  Funding information* Private insurance information
* PMAP
	+ Plan name
	+ ID
	+ Group number
* Service agreement
* Client placement authorization
 |

***Note: All state facilities are non-smoking.*** ***Nicotine replacement: is only nicotine patch (if ordered); no other replacements will be given. Specific allergy issues can be reviewed on a case-by-case basis.***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Site** | **Locked****/Unlocked** | **Licensed** | **Gender** | **Pregnancy** | **Methadone** | **Suboxone / Subutex *with established provider*** |
| Anoka | Locked | MICD | Co-ed | Yes | Yes, Valhalla | Yes |
| Carlton | Locked | MICD | Women only | Yes | Case by case; need federal exception for monthly take outs | Yes |
| Fergus Falls | Locked | MICD | Co-ed | Yes | Case by case; need federal exception for monthly take outs | Yes |

***Note: Predatory/sex offenders are reviewed case-by-case basis. Level and victim demographic can affect ability to admit***

If you have any questions regarding the referral process, **call CPA at 651-431-5337 or 866-966-2337.**

## Client Information

**Date of referral:** mm/dd/yyyy

Client name (First, Middle and Last):       Known aliases:

What are the events contributing to this client’s need for services?

Which C.A.R.E. facility do you prefer the client placed at? Choose Site

**NOTE: a referral to C.A.R.E. will be sent to the next available bed, unless noted otherwise.** If you ***do not*** placement at a certain site, please comment on the reason and location:

Medical Record Number:       ***if referred from another State facility***

SS Number:    -  -     DOB:       Age:       Gender:

Race:       If Native American, which Band are they enrolled in?

Interpreter needed? [ ]  No [ ]  Yes, language:

Client referred by:       Phone number:

Client’s Current Location:       Phone number:

County (or Tribal Band) of financial responsibility:

Does the client have insurance? [ ]  No [ ]  Yes, Name:       Policy:

Is CD Treatment Funding in place? [ ]  No [ ]  Yes, Length of funding approval:

Diagnosis (include MH, CD, medical and surgical history):

Medications:

Allergies:

Any foreign travel in the past 30 days? [ ]  No [ ]  Yes

In the last 30 days has there been any exposure to known infection diseases? [ ]  No [ ]  Yes

|  |  |
| --- | --- |
| Prior CD treatment? | [ ]  No [ ]  Yes, comment: *(list programs previously attended)*Comment:        |
| Chemical use:  | Primary substance of choice:      Secondary substances of choice:       |
| Current withdrawal symptoms? | [ ]  No [ ]  Yes [ ]  Seizures [ ]  Hypertension [ ]  DT’s [ ]  PsychosisOther/Comment:        |
| History of withdrawal symptoms? | [ ]  No [ ]  Yes [ ]  Seizures [ ]  Hypertension [ ]  DT’s [ ]  PsychosisOther/Comment:        |
| History of IV drug use? | [ ]  No [ ]  Yes, within last 3 months [ ]  Yes, more than 3 months agoComment:        |
| Diagnosed with a TBI? *Traumatic Brain Injury* | [ ]  No [ ]  Yes, comment:        |
| Intellectual disability (Diagnosed or suspected)? | [ ]  No [ ]  Yes, comment:        |
| Is the client pregnant? | [ ]  No [ ]  Yes, *if yes provide estimated delivery date*:       ***Note OB provider information on last page for form*** |
| Current or history of sexual aggression? | [ ]  No [ ]  Yes, comment:        |
| Current or history of sexual vulnerability? | [ ]  No [ ]  Yes, comment:        |
| Currently or history of predatory behavior? | [ ]  No [ ]  Yes, comment:        |
| Required to register as a predatory offender? | [ ]  No [ ]  Yes, comment:        |
| Legal/Criminal problems? | [ ]  No [ ]  Yes [ ]  Past [ ]  Pending [ ]  UnknownComment:        |
| Do they need to return to jail? | [ ]  No [ ]  Yes, comment:        |
| On furlough from jail? | [ ]  No [ ]  Yes, comment:        |
| Is this treatment in lieu jail? | [ ]  No [ ]  Yes, comment:        |
| Is this treatment a requirement of probation/parole? | [ ]  No [ ]  Yes, comment:        |
| Are Medications for Opiate Use Disorder (MOUD) planned?e.g., Suboxone, Subutex or Methadone | [ ]  No [ ]  Yes If yes, type of opiate prescribed:      Provider:       *Please attach a Release of Information from the Provider* |
| Current or history of Mental Illness symptoms? | [ ]  No [ ]  Yes, please describe:        |
| Is the client psychiatrically stable? | [ ]  No [ ]  Yes, comment:        |
| Current or history of homicidal ideation/statements? | [ ]  No [ ]  Yes [ ]  Lethal plans? Attempts? Comment:        |
| Current or history of suicidal ideation/plan? | [ ]  No [ ]  Yes [ ]  Lethal plans? Attempts? comment:        |
| Ever engaged in deliberate self-injurious behavior? | [ ]  No [ ]  Yes [ ]  Has needed medical attention/repair?Please describe:        |
| Current or history of verbal aggressive? | [ ]  No [ ]  Yes, (*e.g. threats/intimidation)*Comment:        |
| Current or history of physical assault/aggression? | [ ]  No [ ]  Yes, comment:        |
| Any special care needs? | [ ]  No [ ]  Yes, (*e.g. special diet, cultural / religious needs)* comment:        |
| Any recent injuries? | [ ]  No [ ]  Yes, comment:        |
| Has the client been on 1:1 observation? | [ ]  No [ ]  Yes, indicate length & whether this is a facility policy, comment:        |
| Current or history of communicable diseases? | [ ]  No [ ]  Yes, if yes which? [ ]  HIV [ ]  Hep C [ ]  Impetigo [ ]  TB[ ]  VRE [ ]  MRSA [ ]  Other/comment:        |
| Does the client use devices to assist with walking/mobility? | [ ]  No [ ]  Yes, devices *(e.g. walker, cane, wheelchair)*: Comment:        |
| Does the client use any medical equipment? | [ ]  No [ ]  Yes, devices *(e.g. C Pap)*: Comment:        |
| Will the client bring their own equipment/device with them? | [ ]  No [ ]  Yes, devices *(please list)*:        |
| Current or history of ingestion or insertion of foreign objects? | [ ]  No [ ]  Yes, comment:        |
| Dental concerns? | [ ]  No [ ]  Yes, comment:        |
| Does the client require specialty medications? | [ ]  No [ ]  Yes, list medications *(e.g. HIV, anti-viral, anti-rejection medications)*:        |
| Is the client being treated for other medical conditions? | [ ]  No [ ]  Yes, conditions *(e.g. seizure disorder, dialysis, cancer therapy, orthopedic, surgical issues, bleeding disorders, wound care)*: List conditions:        |
| History of fire setting? | [ ]  No [ ]  Yes, comment:        |
| History of significant trauma? | [ ]  No [ ]  Yes, comment:        |
| History of AWOL, elopement or leaving AMA? | [ ]  No [ ]  Yes, comment:        |

**Is the client restricted to a particular provider or pharmacy?** [ ]  No [ ]  Yes

Provider Name:       Provider Number:

 Clinic Name:       Clinic Number:

**Prescribing pharmacy:**       Phone number:

Address:       Fax number:

**Hospital Social Worker**:       Phone number:

**CD CCM** Name:       Phone number:

 e-mail:       Fax number:

**Mental Health CCM** Name:       Phone number:

 e-mail:       Fax number:

**CCM Supervisor** Name:       Phone number:

 e-mail:       Fax number:

**Guardian:**       Phone number:

**Probation Officer**:       Phone number:

**CHIPS Worker:**       Phone number:

**Adult Protection Worker:**       Phone number:

**Other support (note title):**        Phone number:

**Psychiatrist:**       Phone number:

Address:       Fax number:

 Is this provider willing to continue signing medication orders?[ ]  No [ ]  Yes

If no, who will sign medication orders?

**Primary Care Provider:**       Phone number:

Address:       Fax number:

 Is this provider willing to continue signing medication orders?[ ]  No [ ]  Yes

If no, who will sign medication orders?

**OB Provider:**       Phone number:

Address:       Fax number:

 Is this provider willing to continue treating this person?[ ]  No [ ]  Yes

If no, who will provide obstetric care?

 Due date:

Date of last OB exam:       Next recommended OB exam:

Add any additional comments here: