**Anoka-Metro Regional Treatment Center** (**AMRTC**) and **Community Behavioral Health Hospitals** (**CBHH)** provide specialized inpatient psychiatric care for adults with mental illness within Direct Care and Treatment. There are six CBHH facilities located in Bemidji, Baxter, Fergus Falls, Alexandria, Annandale, and Rochester Minnesota.

**The following information is required for referral processing and should be sent to Central Pre-Admissions (CPA) at the time of referral or as soon as it is available:**

|  |  |
| --- | --- |
| **Legal Information** | |
| **Civil Commitment documents** | **Criminal documents** *(if applicable)* |
| Pre-Petition Screening Report  Petition for Commitment  Petition for Jarvis & ECT/Price Sheppard *(if applicable)*  Examiner’s Report for Commitment  Order for Commitment  Jarvis and/or ECT/Price Sheppard Order *(if applicable)*  Guardianship Order *(if applicable)*  Substitute Decision Maker Order *(if applicable)*  Notice of Intent to Revoke Stay of Commitment *(if applicable)*  Order for Stay of Commitment and Revocation of Stay of Commitment *(if applicable)*  Notice of Intent to Revoke Provisional Discharge *(if applicable)*  Order Revoking Provisional Discharge *(if applicable)* | Any order under Minnesota Statutes section 611.40 – 611.59  Rule 20 Evaluation  Criminal Complaint(s)  Criminal Order Regarding Competency |

***\*All Court Orders should be signed before being sent to CPA***

|  |  |
| --- | --- |
| **Medical/Behavioral Information** | |
| **Hospital/Treatment Facility records** | **Correctional Facility records** |
| Face sheet/Demographic Info  History & Physical  Psychiatric Evaluation/Assessment  Current Medication Administration Record (MAR)  Lab results  Nursing and Provider Progress Notes (at least 7 days)  Social Work Assessment *(if applicable)*  CD Assessment *(if applicable)*  Behavioral Plan *(if applicable)*  Neuropsych testing *(if applicable)* | Health Assessment  Behavior Logs/Incident Reports  Medical/Mental Health Notes  Current Medication Administration Record (MAR)  Lab results  Any available Neuropsych testing |

**In order to determine which program is most appropriate for the referred individual and their prioritization under Minnesota Statutes Section 253B.10 subd. 1(b), please provide any additional information regarding the following:**

* Any medical or other information relevant to the intensity of the treatment needs of the person.
* Any information related to the person’s safety or the safety of others in the person’s current environment.
* Any distinct and articulable negative impacts of an admission delay on the facility referring the person for treatment.

**Date of referral:** Enter date

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

SS Number:    -  -     DOB:       Age:       Gender:

Interpreter needed?  No  Yes, language:

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

County (or Tribal Band) of financial responsibility:

Client referred by:       Phone number:

Client’s Current Location:       Phone number:

Client’s Current Unit/Floor Location:       Phone number (*if different from above*):

Is the client able to access current court ordered treatment?  Yes  No

-If no, explain:

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.)*?

Additional comments:

**Case Manager \****Required contact information; please provide if possible.*

Name:       Phone number:

e-mail:       Fax number:

**Attorney (Civil) \****Required contact information; please provide if possible.*

Name:       e-mail:

**Attorney (Criminal)** *\*If applicable*

Name:       e-mail:

**Hospital Social Worker or Facility Contact Person \****Required contact information; please provide if possible.*

Name:       Phone number:

e-mail:

**Guardian \****if applicable*

Name:       Phone number:

e-mail:

**Probation Officer \****if applicable*

Name:       Phone number:

e-mail: