The Compass Center: A Program of Archway Station, Inc.
418 Warwick Ave., Cumberland, MD 21502
Phone #: (301)722-2018 / Fax#: (301) 722-2711

Referral for Crisis Stabilization Services (CSS)

Inpatient Admission Prevention Level of Care

01/01/2023

ALL INFORMATION ON REFERRAL IS REQUIRED AND MUST BE COMPLETED

Name: ____ Date: ________________________

Address: ____

____

Telephone: _______________________________________ Date of Birth: __________________

Social Security #: __________________________________ Gender: _______ Race: ________

Education: ☐ Below 12th 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: ____

Veteran: ☐ Yes ☐ No VA Income: _____________ VA Medical Benefits: ______________

Medical Assistance #: _______________________________ Medicare #: _____________________

QMB: ☐ Yes ☐ No

Other Medical Insurance: _____________________________ Policy#: _______________________

Other Payment Source(s): ____

A. Eligibility Screening (all must apply)

- ☐ requires inpatient admission prevention level of care not admission alternative
- ☐ for clinical reasons, requires a temporary separation from current living situation
- ☐ person understands and has stated willingness to comply with CSS rules
- ☐ person expects, with staff support, to be able to comply with treatment recommendations
- ☐ person is able, with staff support, to care for physical needs and personal hygiene

Other Required Criteria

- ☐ person is NOT in need of immediate involuntary inpatient psychiatric hospitalization
- ☐ person is NOT a danger to self or others
- ☐ person has NOT voiced being intoxicated by drugs or alcohol, or under the influence in the last 24 hrs
- ☐ person has NOT been declared medically unstable
- ☐ person is NOT taking new or altered dosages of medications that results of which are yet unknown
- ☐ person has been asked about potentially dangerous items in their belongings
- ☐ person is free and/or fully treated against any visual human infestations

B. Diagnostic Information

Primary Diagnosis: ________________________________ Diagnosis Code: _____________

Secondary Diagnosis: ______________________________ Diagnosis Code: _____________

Other Diagnosis: __________________________________ Diagnosis Code: _____________

Diagnosed by: ______________________________ License/Credentials: _______________

Agency: ______________________________________ Date of Diagnosis: ______________

Does the person have a history of drug abuse? ☐ Yes ☐ No
If yes, describe: ____

Does the person have a history of alcohol abuse? ☐ Yes ☐ No
If yes, describe: ____

Does the person have a Developmental Disability? ☐ Yes ☐ No
If yes, describe: ____

Does the person have other physical impairment(s)? ☐ Yes ☐ No
If yes, describe: ____

Presenting Problem(s) (please explain why the person is being referred for crisis services):

____

____

____

____

C. Health Services

Has the person previously been admitted to a psychiatric hospital? ☐ Yes ☐ No

Place of last hospitalization: ____

Other relevant history: ____

Psychiatrist

Name: ____

Address: ____

Telephone #: ______________________________

Therapist

Name: ____

Address: ____

Telephone #: ______________________________

Person has a history of medication non-compliance? ☐ Yes ☐ No

Does the person currently receive psychiatric medication monitoring? ☐ Yes ☐ No

Person is being discharged with 14 days of necessary medications? ☐ Yes ☐ No ☐ N/A

Person agrees that ALL medications including rescue inhalers are not permitted to be carried freely? ☐ Yes ☐ No

Medication	Dosage	Frequency

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

____

Somatic Care Physician
Name: ____

Address: ____

Telephone #: ______________________________

Please indicate or comment on any relevant medical/somatic history including assessment of general physical health (illness, physical disabilities, allergies):

____

____

Physical health assessed by ER physician/somatic physician: ☐ Yes ☐ No Date: __________

If yes, ER physician/somatic physician name and credentials:
____

D. Rehabilitation Services

Is the person currently involved in a structured day program? ☐ Yes ☐ No

Name of program:________________________ Contact person: _____________________

Recommended rehabilitation and/or treatment goals: _______________________________

____

____

Person's discharge plan following 10 day crisis stay: __________________________________

____

E. Authorization for Services

ASO Care Manager (full name): ____

Both Need Requested When Obtaining Authorization

T2048 Residential room and board ☐ Yes ☐ No

H0018 Residential Crisis Services ☐ Yes ☐ No

Date Range ______________ to _____________ Authorization #: ____________________

1:4 staff to person ratio coverage is acceptable for person's needs? ☐ Yes ☐ No

Clinical Rationale: ____

____

Other insurance authorization information (if applicable): ____________________________

____

F. Signatures

Face-to-face evaluation completed by a psychiatrist occurred as part of the referral:

☐ Yes -- If yes, complete Section G

☐ No -- If no, person gives consent to participate in a face-to-face evaluation within 24hrs of admission to crisis services: ☐ Yes ☐ No

Referral source understands that a person discharged for violation of rules or behaviors presenting a risk to self, staff, or others may require emergency care. Secondary level of care or discharges lasting longer than 24hrs will require the submission of a new referral and assessment.

Referral Source: Must be referred by a Licensed Mental Health Professional. A "Licensed Mental Health Professional" eligible to make referrals to a PRP is defined as a Psychiatrist, CRNP-PMH, Licensed Psychologist, LCSW-C, LCPC, APRN-PMH, LCMFT, LCADC, LCPAT, LGMFT, LGADC or LGPAT. LGPC, LGMFT, LGADC, LGPAT and LMSW staff may only make referrals if they are currently in a formal clinical supervision arrangement with a supervisor approved by the Maryland Board of Professional Counselors and Therapists or the Maryland Board of Social Work Examiners, as applicable. (Supervisor's name, title and location must be provided). Referrals from non-mental health professionals who do not have a mental health specialty are not permitted. RN-C, CAC-AD and CSC-AD are not eligible to make referrals. The Licensed Mental Health Professional must be actively enrolled as a Medicaid provider.

____ Date: _______________

Individual Signature

____ Date: _______________

Signature of Referring Mental Health Professional / Physician

____ ______________________

Printed Name **Credentials**

____ Date: _______________

Signature of Supervisor (if applicable)

____ ______________________

Printed Name (if applicable) **Credentials** (if applicable)

G. This following section is to be completed by psychiatrist or appropriately privileged mental health professional:

I have assessed the physical health of this person: ☐ Yes ☐ No
The person needs a physical exam or somatic follow up: ☐ Yes ☐ No
Face-to-face evaluation completed by psychiatrist: ☐ Yes ☐ No

Mental Status Examination/Screening Assessment: ____________________________________

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____

____

____ Date: _________________
Signature of Psychiatrist

____ __________________________
Printed Name **Credentials**

If physical health has not been assessed by a medical professional, a somatic appointment will need to be scheduled no more than 72 hours after admission to residential crisis stabilization services facility.