



# ARCHWAY STATION, INC.

## REFERRAL for CRISIS STABILIZATION SERVICES (CSS)

### Inpatient Admission Prevention Level of Care

**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

<b>Medication</b>	<b>Dosage</b>	<b>Frequency</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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):

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Physical health assessed by ER physician/somatic physician:  Yes  No Date: \_\_\_\_\_

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

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**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: \_\_\_\_\_

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Person's discharge plan following 10 day crisis stay: \_\_\_\_\_

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**E. Authorization for Services**

Select Appropriate Location:

- NPI# The Compass Center (Allegany County): 1053008003
- NPI# Safe Harbor (Garrett County): 1598361941

ASO Care Manager (full name): \_\_\_\_\_

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: \_\_\_\_\_

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Other insurance authorization information (if applicable): \_\_\_\_\_

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**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.

\_\_\_\_\_  
**Individual Signature** Date: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Referring Mental Health Professional / Physician** Date: \_\_\_\_\_

\_\_\_\_\_  
**Printed Name** **Credentials**

\_\_\_\_\_  
**Signature of Supervisor** (if applicable) Date: \_\_\_\_\_

\_\_\_\_\_  
**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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Psychiatrist Date: \_\_\_\_\_

\_\_\_\_\_  
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.***