SilverCare

Date **Time** **PART A Completed By:**

Caller Name/Title: Phone #

Company: Address:

City: County: Zip Code:

Patient Referred By: Primary MD Tel #

Patient Resides at: SNF ☐ Home ☐ Group Home ☐ Assisted Living ☐ Other ☐ _____

PART A: PATIENT INFORMATION

Patient Name: Age: DOB:

Male: Female: Address:

City: County: Zip Code:

Insurance: Primary: #: Secondary: #:

SSN # DPOA/Guardian/ Family Name: Phone:

Three (3) questions to establish capacity to consent for admission as a voluntary patient when appropriate

Who are you?☐ Where are you?☐ Why are you here?☐

PART B: PRE-ADMISSION SCREENING **PART B & C Completed By:**

Date/Time

REASON FOR REFERRAL:

ADMISSION CRITERIA: *Check all that apply*

	Suicidal Ideation/plan/attempt		Acute severe exacerbation of chronic symptoms
	Requires intensive follow-up		Assaultive destructive behavior/assaultive/poor impulse control
	Risk due to disorientation/impairment		Medication withdrawal change toxic effects or non-compliance
	Failed less intensive level of care		Psychiatric symptoms severe causing bizarre disordered behavior

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	Sleep/nutrition disturbance poses risk		Other: *Describe:*

Current Medical Condition(s):

Medically Cleared by:

Medications (Include Non-Prescription):

PART C: DISPOSITION AND STATUS Date: Time:

Please check the box(s) that apply

	General information only		Ref. source chose another facility		Administrative denial
	Clinical admission criteria not met		Failed to keep appointment		At baseline functioning
	Medically unstable		Non-participating PPO/HMO		Physician declined to admit
	Pt/family refused		Unable to follow up		Age inappropriate
	Pt/family chose another facility		No space available: *current census #*		Not appropriate for milieu
	Census cap staffing		Census cap/environment		Census cap/other

Referral Instructions:

Admission Date: Time: Voluntary: Involuntary:

Authorizing Physician: Attending Physician:

Review Date: Time: PD Signature: