REGIONAL FORENSIC PSYCHIATRIC CENTER PREADMISSION CONTACT

NAME:_____ _____ ___ _____**AKA:**_____
LAST FIRST MI (MAIDEN)

ADDRESS:_____ ☐**M** ☐**F**

SS#:_____ **MARITAL STATUS:**_____**RELIGION:**_____

DATE OF BIRTH:_____**AGE:**_____ **RACE:**_____ **OCCUPATION:**_____

VETERAN:_____**BRANCH:**_____

ETHNICITY:_____**PRIMARY LANGUAGE OTHER THAN ENGLISH:**_____

LEVEL OF EDUCATION:_____

NEW ADM ☐ **READM** ☐ **DATE LAST DISCHARGE:** _____**UNIT:**_____

COUNTY OF RESIDENCE:_____**COMMITTING COUNTY:**_____

COMMITMENT TYPE (Please check all that apply): ☐**304** ☐**304g2** ☐**305** ☐**402** ☐**403** ☐**405**

OTHER (Please provide explanation): _____

MOST RECENT COMMITMENT DATE:_____

REASON FOR REFERRAL AS WRITTEN ON THE COURT ORDER: _____

_____

CHARGES:_____

DATE OF INCARCERATION: _____ **ANTICIPATED COURT DATE:**_____

MAX-OUT DATE:_____

JUDGE:_____ **PHONE #:**_____

DEFENSE ATTORNEY:_____**PHONE #:**_____

MEDICAL DEPARTMENT CONTACT:_____ **PHONE #:**_____

BSU LIAISON:_____ **PHONE #:**_____

COMMUNITY CASE MANAGER(ICM, CTT, ETC)_____

PHONE# WORK:_____**CELL:**_____

DATE BSU NOTIFIED OF TRANSFER TO RFPC:_____ ☐ **AGREE** ☐ **DISAGREE**

PSYCHIATRIC/MEDICAL DIAGNOSIS(ES) – *Please enter all known conditions*

AXIS I	AXIS II	AXIS III	AXIS IV	AXIS V

REASON FOR INCOMPETENCY IF FOUND INCOMPETENT:

_____

_____

HIGH RISK BEHAVIOR: (*Past/Present)*

☐ **Suicide Attempt(s); Date(s); Method(s)**_____

☐ **AWOL History** ☐ **Self-Mutilative** ☐ **Homicidal**

☐ **Anorexic** ☐ **Self-Abusive** ☐ **History of Fire Setting**

☐ **Polydipsia** ☐ **Assaultive/Destructive** ☐ **Sexually Aberrant Behavior**

☐ **PICA** ☐ **Uncontrolled Seizure Disorder**

Other (please be specific)_____

_____

CURRENT MEDICATIONS: (*Psychiatric and non-Psychiatric*)

Name of Medication	Dosage	Reason for Medication	Start Date	Takes Meds Yes/No

If additional space is needed for medication, please continue on page 4

OVER THE COUNTER MEDICATION OR HERBAL SUPPLEMENTS:_____

_____

DRUG ALLERGIES (Specify Reaction): _____

FOOD ALLERGIES (Specify Reaction):_____

SPECIAL DIET:_____

ENVIRONMENTAL ALLERGIES: _____

PREADMISSION CONTACT NAME:_____

PHYSICAL PROBLEMS (Including recent injury(ies); chronic pain; sensory limitation or others as noted):

_____

_____

_____

ANY CURRENT/ACUTE/CHRONIC INFECTIOUS DISEASE? ☐ YES ☐ NO If yes, explain_____

_____

AMBULATION: UNAIDED ☐ CANE ☐ CRUTCHES ☐ WALKER ☐ WHEELCHAIR ☐PROSTHESIS ☐

SPECIFY:_____

IMMUNIZATIONS (Include PPD)	DATE ADMINISTERED
1.	
2.	
3.	

RECENT PSYCHOLOGICAL TESTS: ☐ YES ☐ NO DATE OF REPORT: _____

PRIOR PSYCHIATRIC HOSPITALIZATIONS: _____

_____

_____

DRUG, ALCOHOL AND NICOTINE HISTORY:_____

DRUG AND ALCOHOL TREATMENT HISTORY: _____

_____

ADVANCE DIRECTIVES: MEDICAL: YES ☐ NO ☐ PSYCHIATRIC: YES ☐ NO ☐

ORGAN DONOR: ☐ YES ☐ NO

INCOME: ☐YES ☐ NO SOURCE:_____ **AMOUNT:**_____

MEDICAL INSURANCE INFORMATION:_____

MEDICAL ASSISTANCE #: _____**MEDICARE#:**_____

MEDICARE D PLAN: _____ **ID #:**_____

NEXT OF KIN/SIGNIFICANT OTHERS:

(1)NAME:_____ **RELATIONSHIP:** _____

ADDRESS_____ **CITY, STATE, ZIP CODE**_____

PHONE: (H)_____**(W)**_____**CELL PHONE**_____

(2)NAME:_____ **RELATIONSHIP:** _____

ADDRESS:_____ **CITY, STATE, ZIP CODE**_____

PHONE: (H)_____**(W)**_____**CELL PHONE**_____

PREADMISSION CONTACT NAME:_____

THE FOLLOWING DOCUMENTATION IS REQUIRED:

1. **Affidavit of Probable Cause** ☐

2. **Copies of Assessments:**
   - ☐ **Psychiatric**
   - ☐ **Nursing**
   - ☐ **Social**
   - ☐ **Psycho-social**
   - ☐ **Medical**
   - ☐ **Competency Evaluation**
   - ☐ **Psychological testing**
   - ☐ **Other disciplines involved in patient's care**

3. **Copies of Reports:**
   - ☐ **Consultations**
   - ☐ **Laboratory Reports and/or other medical studies performed including:**
   - ☐ **Chest X-Ray; EKG; EEG; HIV; Hepatitis; TB; CBC; SMAC; WBC; PPD**
   - ☐ **Medication related blood levels**
   - ☐ **Certificate of Need (if under age 22)**

4. **Copies of Progress Notes and Physician's Orders for at least the last three (3) weeks** ☐

5. **Copy of current Treatment Plan** ☐

(Continued)CURRENT MEDICATIONS: (*Psychiatric and non-Psychiatric*)

Name of Medication	Dosage	Reason for Medication	Start Date	Takes Meds Yes/No

SIGNATURE: _____ **DATE:**_____

PRINTED NAME/ TITLE:_____

PLEASE FAX COMPLETED REFERRAL TO:_____ **AT:** _____

OR VIA *ENCRYPTED* EMAIL COMPLETED REFERRAL TO:_____

AT EMAIL ADDRESS: _____

Print Form