



Helping People - Supporting Communities - Changing Lives

Phone 315-598-4194 | FAX 315-598-1012

Mental Health Residential Crisis Services
354 East Broadway, Fulton, NY 13069

Phone: 315-598-9110 or 315-598-4194
Fax: 315-593-1012

CRISIS REFERRAL FORM

BACKGROUND INFORMATION:

Name: _____ **Medicaid #** _____

Social Security # _____ **DOB:** _____ **Gender:** _____

Address: _____ **Phone:** _____

Date referred: _____ **Requested Date of Admission:** _____

DIAGNOSIS:

Primary Mental Health Diagnosis: _____

Substance Use Diagnosis: _____

Known Allergies and Medical Concerns: _____

Reasons for using the Crisis Bed and anticipated length of stay: _____

ELIGIBILITY:

- Does the client have a stable home to return to? Yes _____ No _____
- Is client able to self-preserve in event of emergency? Yes _____ No _____
- Is the client a threat to themselves or has suicidal ideations? Yes _____ No _____
- Is client a threat to others or has homicidal ideations? Yes _____ No _____
- Is client a registered sex-offender? Yes _____ No _____

Referral Source

Referring Agent: _____ **Phone:** _____ **Email:** _____

Referring Agency: _____ **Phone:** _____ **Fax:** _____

Address: _____
_____ =

Office Use Only:

Crisis Need: _____ Standard Crisis bed admission

_____ Enhanced Crisis bed admission- Requires prior approval from Director of Community Resources



THIS FORM MUST BE COMPLETED IN ITS ENTIRETY, SIGNED AND DATED.
MENTAL HEALTH CRISIS BED

ASSESSMENT OF ABILITY TO SELF-MEDICATE

Consumer's Name: _____

[x] Initial Assessment

The below criteria is the referring agents assessment of the consumer.

		YES	NO	COMMENTS
1.	Can Correctly name all medications			
2.	Knows purpose of each drug			
3.	Knows correct time to take medication			
4.	Correctly states dosage			
5.	Correctly states special instructions			
6.	If appropriate, has awareness of possible side effects			
7.	Understands proper storage procedure.			
8.	Knows how to handle special circumstances such as:			
	a. Takes the wrong medication			
	b. Misses a dose			
	c. Takes too much			
	d. Feels medication looks different than usual			
	e. Wishes to combine over the counter drugs and/or alcohol with prescribed medication			
9.	Realizes the importance of telling <u>all</u> their doctors what medications have been prescribed for them			

The below recommendation was based on the factors above

2. The Assessment found that she/he:
- ___ (1) is capable of self-administering medication
 - ___ (2) is capable of self-administration of medication when reminded or supervised
(See "comments" below)
 - ___ (3) neither of the above, (See "comments" below)

COMMENTS:

Signature and title of person complete assessment

Date



MENTAL HEALTH CRISIS BED

PRESCRIBED MEDICATION

Consumer's Name: _____

Date: _____

Address: _____

Attending Physician: _____

Current Medications:

Ordered by Mental Health Division:

	<u>Medications</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Physician</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____
11.	_____	_____	_____	_____
12.	_____	_____	_____	_____
13.	_____	_____	_____	_____
14.	_____	_____	_____	_____

Known Drug Allergies:

1. _____
2. _____
3. _____
4. _____

Physician's Signature: _____



Physician's Recommendation for Over-the-Counter Medications

NAME: _____

AGE: _____

ALLERGIES: _____

PHYSICIAN: _____

(Please make a check mark where applicable)

Medication	Dosage	Frequency / Special Instructions	Recommended	Not Recommended
Tylenol / Acetaminophen	325 mg tabs / caps	Per Label Directions		
Extra-Strength Tylenol / Acetaminophen	500 mg tabs / caps	Per Label Directions		
Ibuprofen / Motrin	200 mg 500 mg 600 mg	Per Label Directions		
Aspirin	81 mg 325 mg 500 mg	Per Label Directions		
Hydrocortisone / Benadryl / Caladryl creams / lotions	Topical Ointments	Per Label Directions		
Bactine / Neosporin First Aid Creams Bacitracin		Per Label Directions		
Hydrogen Peroxide		Per Label Directions		
Decongestants Cough Suppressants		Per Label Directions		
Stimulants: Diet Pills Caffeine Pills		Per Label Directions		
Tums Anti-Acid tabs or suspensions		Per Label Directions		

The above named consumer's current medication regime, diagnosis / health concerns and allergies have been reviewed. There are no known contradictions / interactions involving their regular medications and these OTC medications. If the consumer requires the use of two consecutive dosages, or if the consumer is not feeling better, you will be notified for further recommendations. Unless otherwise indicated, these orders are in effect for one year.

PHYSICIAN'S SIGNATURE: _____

DATE: _____

Crisis Bed Application Procedures

The following is required for the referral to the crisis bed.

1. Referring agent contacts the crisis residence to request bed availability, complete a phone screening and **request approval for admission by calling 315-598-9110 – Ewelina Wojnowska, Mental Health Transitional Living Program Coordinator or 315-598-4194 POC – Ryan Pekarek, Residence Senior Counselor.**
2. Fax application packet to OCO MH Crisis residence at 315-593-1012. This includes, **referral, Columbia suicide assessment, ability to self-medicate, current medication list, and hospital discharge instructions and psychiatric assessment if available.**
3. Prescribing authority will provide prescribed medications for the applicant and referring agent will ensure active insurance to fill prescriptions at pharmacy.
4. Referring agent will assist with arranging transportation of the individual to the residence.
5. All original paperwork including written scripts must be sent to or accompany the applicant to the Crisis Residence.

All referrals for Admission Diversion must be screened by use of the Columbia Suicide Severity Rating Scale and requires the approval of the Residential Crisis staff prior to arrival to the site.

Crisis Bed Admission Criteria

In order to be admitted to the Crisis Bed Program, an individual must:

- *Be age 18 or older.
- *Be diagnosed with a mental illness, as designated by the DSM-V. The primary diagnosis **must not be** alcohol or drug disorders, dementias and other disorders caused by general medical conditions, developmental disabilities or social conditions.
- *Currently have need for respite care to either divert an admission to a hospital for mental health concerns, or as a means of stepping down from a hospitalization.
- *Be a resident of Oswego County
- *Be able to successfully be able to self-preserve in the event of an emergency.
- *Be capable and motivated to perform basic self care and daily living functions.
- *Agree to comply with Admission Agreement.

An individual CANNOT be admitted to the Crisis Bed Program if he/she:

- *Are under the age of 18 years old.
- *Currently present a serious threat to him/herself and/or others.
- *Have a recent history of arson, homicide, violent/aggressive behavior or violent sexual behavior.
- *Are considered to be “under the influence of alcohol/substances.” “Under the influence” would be considered as: BAC .08 or more and or known to be under the influence of substances and or exhibiting behaviors of intoxication/drug abuse behaviors not solely due to mental health symptoms, such as aggressive/violent physical or verbal behavior, excessive slurring of speech, unsteady gait, other obvious signs of intoxication/abuse.