Mental Health Residential Crisis Services
354 East Broadway, Fulton, NY 13069
Phone: 315-598-4194
Fax: 315-593-1012

CRISIS REFERRAL FORM

Crisis Need: ☐ **Admission Diversion** (W/ 24 hour supervision) ☐ **Hospital Step Down** (W/ 24 hour supervision)

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** ☐

For admission please include referral to SPOA for Care Coordination, Current list of medications, and discharge orders and brief psychiatric or social summary as available.

Referral Source

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

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

Address: _____

_____

This form MUST BE COMPLETED IN ITS ENTIRETY, SIGNED AND DATED.

MENTAL HEALTH TRANSITIONAL LIVING PROGRAM

ASSESSMENT OF ABILITY TO SELF-MEDICATE

Consumer's Name: _____

[x] Initial Assessment

[] Annual Update

1. **The below criteria is staff's assessment of the consumer. This criteria should be used by the physician to determine a recommendation of the consumer's ability to self medicate.**

		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:

Physician Signature:_____ **Date:** _____

MENTAL HEALTH TRANSITIONAL LIVING

SUICIDE ASSESSMENT FORM

I, the undersigned, as a physician licensed to practice medicine in the State of New York, have examined _____ _____and assessed him/her for suicidal potential.

I have found the above named individual not to be a present danger to him/herself or others, nor to be actively suicidal at this time, and therefore, inappropriate for admission to the inpatient unit of Oswego Hospital Behavioral Services Division.

_____, MD _____
Physician Signature Date

_____
Printed Name of Physician

MENTAL HEALTH TRANSITIONAL LIVING

PRESCRIBED MEDICATION

Consumer's Name: _____ Date: _____

Address: _____

Attending Physician: _____

Current Medications:
Ordered by Mental Health Division:

	Medications	Dosage	Frequency	Physician
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				

Known Drug Allergies:

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

Physician's Signature: _____

OCO Inc. Residential Services Department 239 Oneida Street | Fulton, NY 13069

Helping People - Supporting Communities - Changing Lives Phone 315-598-4194 | FAX 315-598-1012

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

Upon determination that in individual seen for mental health emergency services is not in need of psychiatric hospitalization/ inpatient services and would benefit from Residential Crisis service, the following is required for the referral to the crisis bed.

1. Referring agent contacts the crisis residence to request bed availability and **request approval for admission by calling 315-598-4194. POC – Elizabeth Bonner/MHTL Program Manager, Victoria Crisafulli MHTL Senior Advocate or 315-598-9110 – Jessica Hotaling, Mental Health Services Program Coordinator.**

2. **OHBSD/Emergency Services staff or other authorized mental health provider completes the application form**, this requires the signature of the treating physician/ physician assistant / nurse practioner or registered nurse.

3. Fax application packet to OCO MH Crisis residence at 315-593-1012. This includes, **referral, suicide assessment, ability to self-medicate, current medication list, and hospital discharge instructions and psychiatric assessment if available.**

4. Prescribing authority will provide prescribed medications for the applicant and referring agent will ensure active insurance to fill prescriptions at pharmacy.

5. Referring agent will authorize transportation of the individual to the residence.

6. All original paperwork including written scripts must be sent to or accompany the applicant to the Crisis Residence.

The Application must be completed in its entirety, with a physician, physician assistant / nurse practioner or registered nurse signature and dated.

All referrals for Admission Diversion must be screened by use of the Columbia Suicide Severity Rating Scale by a physician, physician assistant / nurse practioner or registered nurse 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.
*****Currently receive mental health services through Oswego Hospital, ARISE or other mental health or medical treatment provider.
*****Be willing to follow through on recommended mental health treatment, including cooperation with administration of any prescribed medications.
*****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.