Sanctuary Psychiatric Centers of Santa Barbara

REFERRAL FORM

CLINICAL INFORMATION: (Note: * = Required Data)

*Referring Agency:____________________________________ *Phone:______________________

*Person completing this form:______________________________ *Date:______________________

Authorization: "I authorize the transmission of information concerning my history, care and treatment to authorized personnel at Sanctuary Psychiatric Centers. This authorization is granted on condition that due care be exercised at all times with respect to my rights to privacy and confidentiality. This authorization is not a waiver of any privilege conferred on me by law or regulation."

*Signed:____ *Date:________________________

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*Client Name: ____ *Phone: _____________________

*Address: ____

*Date of Birth: ______________________ Age: ___________ *Gender: _______________________

*Marital Status: ____________________ *Ethnicity: _________________ Religion: ______________

Medi-Cal # __________________________ *Social Security # ______________________________

* Other Health Insurance ________________________

*Source of Income: SSI Family Other______________ Approved?________

*Conservatorship – Finances?________ Personal?________ Expiration Date: _________________

Conservator Name:_____________________________________ Phone:________________________

*Parent/Guardian Name(s):____

*Marital Status: ___________ *Phone Number(s): ____

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*Diagnostic Impression –

Axis I ____

Axis II ____

Axis III ____

Axis IV ____

Axis V GAF ____ Date:__________________

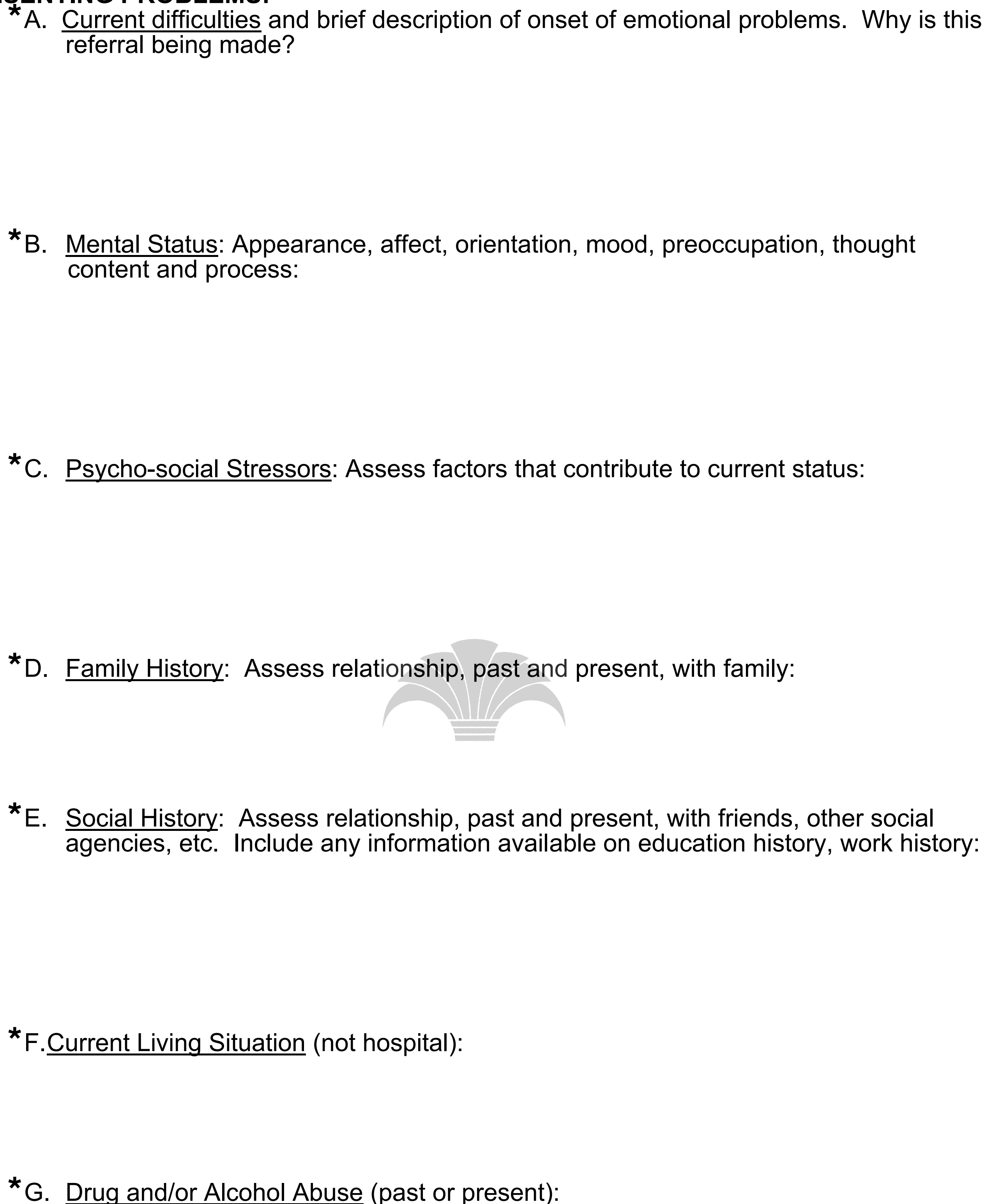
I. PRESENTING PROBLEMS:

*A. Current difficulties and brief description of onset of emotional problems. Why is this referral being made?

*B. Mental Status: Appearance, affect, orientation, mood, preoccupation, thought content and process:

*C. Psycho-social Stressors: Assess factors that contribute to current status:

*D. Family History: Assess relationship, past and present, with family:



*E. Social History: Assess relationship, past and present, with friends, other social agencies, etc. Include any information available on education history, work history:

*F. Current Living Situation (not hospital):

*G. Drug and/or Alcohol Abuse (past or present):

*H. Suicide Attempts and/or Ideation (include means of attempt, past or present):

II. CRIMINAL HISTORY

*I. Previous engagement in violent or other anti-social activity:

Please assess current potential for violence:

*J. Current Legal Status (probation, court date(s), charges pending):

III. TREATMENT HISTORY:

*A. State or Other Psychiatric Hospitalizations: Include locations, dates and durations, if information available. Include drug treatment history. Describe precipitant factors:

*B. Therapy contacts: Past and present, in addition to referring agency: Include out patient programs

C. Physician (*Last Name):_________________________ (*First):_________________

Address: ____ *Phone: ____________

D. Psychiatrist (*Last Name):_______________________ (*First): _________________

Address: ____ *Phone: ____________

IV. MEDICATION EVALUATION/MEDICAL CONCERNS:

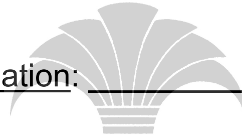
*A. Medication: Type, dosage, length of time on these medications:

*B. Drug Allergies:

*C. Other Allergies:

*D. Describe General Physical Health and Medical Concerns:

*E. Dietary restrictions:



*F. Date of last Physical Examination: ________________ *Results: ___________________

*G. Medical Devices (e.g. contact lenses, IUD, pacemaker, etc.)

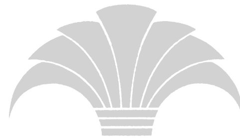
*H. Seizure history & activity in past year:

V. TREATMENT PLANNING:

*A. Describe treatment plan developed by your agency or which you would consider appropriate for this client:

*B. What areas would you consider to be potential problems for this client in a group living situation (cooking, cleaning, use of free time, etc.)?

Signed by:____ Date:___________



Sanctuary Psychiatric Centers of Santa Barbara

FOR ADDITIONAL COMMENTS, PLEASE USE ADDITIONAL SHEETS

- ***PLEASE ATTACH ALL APPROPRIATE DISCHARGE MATERIAL OR MAIL AS SOON AS POSSIBLE.***

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Please return to:
DDX Program Director
Sanctuary Psychiatric Centers of Santa Barbara
P. O. Box 551
Santa Barbara, CA 93102

Telephone: (805) 569-2785 **Fax: (805) 563-1977**

PREPLACEMENT APPRAISAL INFORMATION

Admission-Residential Care Facilities

NOTE: *This information may be obtained from the applicant, or his/her authorized representative. (Relatives, social agency, hospital or physician may assist the applicant in completing this form.) This form is not a substitute for the Physician's Report (LIC 602).*

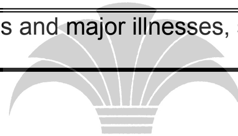
APPLICANT'S NAME	AGE

HEALTH (Describe overall health condition including any dietary limitations)

PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech)

MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn)

HEALTH HISTORY	(List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)



SOCIAL FACTORS (Describe likes and dislikes, interests and activities)

BED STATUS

OUT OF BED ALL DAY IN BED ALL OR MOST OF THE TIME IN BED PART OF THE TIME	COMMENT:

TUBERCULOSIS INFORMATION

ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY? YES NO	DATE OF TB TEST	POSITIVE NEGATIVE
ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS? YES NO	ACTION TAKEN (IF POSITIVE)	

GIVE DETAILS

AMBULATORY STATUS (this person is ambulatory nonambulatory)

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device. An ambulatory person must be able to do the following:

YES	NO	
		Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
		Mentally and physically able to follow signals and instructions for evacuation.
		Able to use evacuation routes including stairs if necessary
		Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation)

FUNCTIONAL CAPABILITIES (Check all items below)

YES	NO	
		Active, requires no personal help of any kind – able to go up and down stairs easily
		Active, but has difficulty climbing or descending stairs
		Uses brace or crutch
		Feeble or slow
		Uses walker. If yes, can get in and out unassisted? Yes No
		Uses wheelchair. If Yes, can get in and out unassisted? Yes No
		Requires grab bars in bathroom.

Other: (Describe) ____________________

SERVICES NEEDED (Check items and explain)

YES	NO	
		Help in transferring in and out of bed and dressing ____________
		Help with bathing, hair care, personal hygiene ____________
		Does client desire and is client capable of doing own personal laundry and other household tasks (specify) ____________
		Help with moving about the facility ____________
		Special diet/observation of food intake ____________
		Toileting, including assistance equipment, or assistance of another person ____________
		Continence, bowel or bladder control. Are assistive devices such as a catheter required? ____________
		Help with medication ____________
		Needs special observation/night supervision (due to confusion, forgetfulness, wandering) ____________
		Help in managing own cash resources ____________
		Help in participating in activity programs ____________
		Special medical attention ____________
		Assistance in incidental health and medical care ____________
		Other "Services Needed" not identified above ____________

Is there any additional information which would assist the facility in determining applicant's suitability for admission? Yes No
If yes, please attach comments on separate sheet.

To the best of my knowledge; I (the above person) do not need skilled nursing care.

SIGNATURE	DATE COMPLETED
APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE	
SIGNATURE	DATE COMPLETED
LICENSEE OR DESIGNATED REPRESENTATIVE	