Geri Psych Referral

Patient Name:	**Age:**	**Sex:**
Address: _____ **City/State/Zip:** _____ **County:** _____ **Telephone:** _____	**DOB:** _____ **Social Security #** _____	
Next of Kin: _____ **Relationship:** _____ **Telephone #:** _____	**Legal Status:** _____ **POA:**_____ **Guardian:**_____ **Voluntary** _____ **Involuntary** _____	

CURRENT CONDITIONS

Presenting problems – Unusual behaviors:

When did problem start?

Have you had treatment for these symptoms in the past? _____Yes _____ No

History of relevant psychiatric treatment:

Current Level of Functioning: Independent _____ Up with 1 assist _____ Up with 2 assist _____
Bedbound_____ Wheelchair:_____Other: _____

Any of the following present: Foley_____ CPAP_____ O2_____ PEG Tube_____ IV_____
Other:_____

Current Medical Conditions:

Current Living Arrangements:

Plans for Living Arrangements on Discharge:

Referral Source Information

Contact Name: **Telephone #:** **Fax #:**

Organization:

Address: **City/State/Zip:**

Please attach:
• Current medication list
• Current labs (within last 24 hours), including: CBC, CMP, TSH, UDS, UA, lithium and/or depakote levels (as applicable), BAL, Vitamin B12, Magnesium
• Most recent doctor visit/progress note (if available)
• Current EKG (within last 24 hours)

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Please note, we cannot accept patients who are on supplemental oxygen, currently on dialysis, receiving any IV medications, patients with tracheostomies, or who would be unable to leave their room to participate in treatment.

Patients must be willing to sign in for voluntary admission. If the patient does not have capacity for medical decision making, next of kin must be available for consent.

↓ OHTLMC GP STAFF USE ONLY ↓

Inquiry Date/ Fax Received: _____ Inquiry Time/ Faxed Received: _____ Received by: _____ Information given to GP staff via telephone: Yes ____No___ Information obtained from: _____
Disposition (Please fill in with date/times of communication): Denial: _____ If yes, detailed reason why :_____ Accepted: _____ Provider giving disposition: _____ Date/Time:_____

Patient Label