

# GRN E-CSP Referral/Preadmission Form

## Referring Party:

Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Agency \_\_\_\_\_

## Consumer Information:

Name \_\_\_\_\_ DOB \_\_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Primary Language \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

County of Residence \_\_\_\_\_

Legal Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_

Legal Guardian Address (if different from Consumer) \_\_\_\_\_

\_\_\_\_\_

Guardian Contact Number \_\_\_\_\_

Current Living Situation: \_\_ Home \_\_ Homeless \_\_ Shelter \_\_ Group home \_\_ Other

Insurance Provider \_\_\_\_\_

Policy No. \_\_\_\_\_

Community Mental Health Provider \_\_\_\_\_

## Is child/adolescent experiencing the following? (Check all that apply)

- Severe Situational Crisis
- SED (Severe Emotional Disturbance)
- Substance Related Disorders
- Co-Occurring Substance Related and Mental Illness
- Co-Occurring Mental Illness and Mental Retardation (\*Focus of Treatment must be AXIS I) MR \_\_ Mild \_\_ Moderate \_\_ Severe \_\_ Profound \_\_ Unspecified
- Co-Occurring Substance Related and Mental Retardation (\*Focus of Treatment must be AXIS I) MR \_\_ Mild \_\_ Moderate \_\_ Severe \_\_ Profound \_\_ Unspecified

**Does child/adolescent meet the following criteria? (Check all that apply)**

- Treatment at a lower level of care has been attempted or given serious consideration **and**
- Child/Youth is experiencing a severe situational crisis, which has significantly compromised safety and/or functioning.
- Child/Youth presents a substantial risk of harm or risk to self, others, and/or property or is so unable to care his or her own physical health and safety as to created a life-endangering crisis.
- Child/Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis.
- Child/Youth demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis.

**Is the Child/Youth?**

- Voluntary (Must be accompanied by Parent/Guardian)
- Involuntary (Must Attach 1013)

**Presenting Problem** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Special Alerts/Risks** \_\_\_\_\_

\_\_\_\_\_

**Reporting Problems:**

**Hallucinations:** \_\_Auditory \_\_Visual \_\_Tactile \_\_Gustatory \_\_Olfactory

**Violent/Dangerous Behaviors:** \_\_Suicidal Threats/Gestures \_\_Homicidal

Threats/Gestures \_\_Destructive Behavior \_\_Confused Behavior \_\_Self Injurious Behavior

\_\_Mania \_\_Delusions

**Alcohol and Drug Use (Send UDS if available):** \_\_ Alcohol Abuse/Dependence

\_\_Drug Abuse/Dependence \_\_Intoxicated \_\_Need Detoxification \_\_In Withdrawal

\_\_Blood Alcohol Level \_\_Elevated Vital Signs \_\_Hx of DTs \_\_Hx of Blackouts

**Vital Signs:**

B/P \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_ Temperature \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Allergies \_\_\_\_\_

**Medical Problems:**

\_\_\_ Asthma \_\_\_ Diabetic \_\_\_ HBP \_\_\_ Thyroid D/O \_\_\_ Seizure D/O

\_\_\_ History of Trauma \_\_\_ Loss of Consciousness \_\_\_ History of Head Injury

Does consumer have other Medical/Physical problems/limitations? \_\_\_ If yes please explain

\_\_\_\_\_  
\_\_\_\_\_

Is the Consumer Pregnant? \_\_\_ YES \_\_\_ NO If yes, gestation time \_\_\_\_\_

**Current Medications** (please list here or fax those taken in the last week):

Name	Amount	Frequency	Last Taken

**Alcohol and Drug Use:**

Name	Amount	Frequency	Last taken

**\*\*\*\*Please send all Labs (CBC, CMP, UA and UDS)\*\*\*\***

**Child/Adolescent can not be considered for admission if any of the following conditions are present:**

1. Burns (severe) requiring acute care or physical therapy
2. Cardiac disease, unstable, including:
  - Brachycardia below 60/ minute, symptomatic, persistent
  - Tachycardia above 120/ minute, symptomatic, persistent

3. Delirium
4. Dementia
5. Fracture, open or closed, and unstable
6. GI bleed, active
7. Infectious disease requiring isolation or treatment by IV antibiotic
8. Intravenous fluids or IV antibiotics
9. Joint dislocations, acute, until reduced
10. Laceration or draining wound, open, requiring packing changes
11. Medical devices used that cannot be secured
12. Oxygen dependent
13. TB, active
14. Traumatic Brain Injury
15. Tubes or drains, chest or abdominal, including ostomies (unless the patient provides their own ostomy care)
16. Dialysis or those with acute chronic renal compromise of a severe nature
17. Pregnant with active OB issues

I hereby certify to the best of my knowledge the referred youth does **not** suffer from the above listed conditions

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Title \_\_\_\_\_

**GRN STAFF USE ONLY**

Consumer referred to GRN C&A CSP for Evaluation/Admission? YES NO

If no, reason for denial \_\_\_\_\_

Denied consumer received alternative referral? YES NO

If yes where was consumer referred \_\_\_\_\_