CTH Admission Requirements

Required Information	Documents Accepted
Medical Orders signed by MD, NP, PA	• REACH medication order form • Pharmacy print outs signed • Prescriptions- sent to pharmacy or physical copies • MAR signed
TB Screening	• VDH TB screening form • Chest X-ray within last year • PPD reading within last year
Guest Profile	REACH Guest Profile form
Emergency Contacts	REACH Emergency Contacts form
Authorization for Medical Treatment	REACH Authorization for Medical Tx
Crisis Assessment	Completed in MyAvatar
Crisis Education & Prevention Plan (completed within last year)	REACH CEPP
Confirm 7 days' worth of all medications, to include photos of med labels and pill count for each.	
Hospital step downs only:	
Recent MARs and progress notes	
Out of region admission only:	
Referral form for Region 4 REACH	

Questions to Gather for CTH Triage

Questions to gather prior to triage:

1. What is the contact information for the guardian? (Name, Number and Email)
2. Does the individual want to come and agree to participate?
3. What are the current medications, where are they physically at right now and can we have photos taken of the bottles/packs and sent to us?
4. When was the last med change?
5. Historically and currently speaking, are they compliant with medications?
6. What pharmacy do they use?
7. Who is the psych doc?
8. When was the last and when is the next psych appt
9. Who are the current providers? (i.e. outpatient therapy, Bx specialist, ABA, etc.)
10. Are there any history of seizures or diabetes?
    a. If so, what is the safety protocol for this? Can this be sent to us ASAP?
    b. For seizures:
       What type of seizures are they?
       How long do they last?
       How frequent are they?
       Are there any know triggers?
    c. For diabetes:
       What type of diabetes is it?
       Who is the physician that is monitoring it?
       What are the dietary restrictions?
       Are they any fluid restrictions?

11. Are there any other known medical conditions? (i.e. high blood pressure, constipation)
12. Any known allergies/any known food restrictions/any special diets
13. Will the individual need any assistive devices while in the home (i.e. wheelchair, walker, cane, breathing apparatus, safety gear, etc.)
    a. If so this will need to be added to the Reach medical order form
14. What has the individual's bxs looked like in the past 48 hours?
15. Are they actively SI or HI with plan and intent? If so what is this?
16. Any physical or medical restraints?
    a. If so, when was the last one?
17. Any sexualized behaviors?
18. How long have they been at their current GH/placement and can they return there?
    a. If not, what is the plan to find alternative housing?

Medication Orders for Adult Crisis Therapeutic Home
Tel: 804-637-1305 Fax: 804-715-4083

GUEST NAME: _____ DOB: _____
MEDICAID NUMBER: _____

Dietary supplements/dietary orders (e.g. consistency, special diet/restrictions):	
Adaptive equipment orders:	
Transportation orders:	
OT/ PT/ other special instructions (oxygen, blood pressure, etc.):	
Medical/Physical Limitations to Activities:	

Standing Medication Orders

Standing Orders required for children under 12 years of age and are preferred for individuals 12 years of age and older

- Please place a **check mark √** in the blank beside orders that **you approve**.
- Please **~~strikethrough~~** orders that you **do not approve**.
- Please **initial the bottom of the first page** and sign the bottom of the second page.

_____ 1. ALLERGIES

Loratadine (Claritin) 10 mg tabs. Take 1 tab PO Q24H PRN for allergy symptoms (itchy, watery eyes, sneezing, runny, itchy nose, and nasal congestion).
Diphenhydramine (Benadryl) 25 mg tabs. Take 1 cap PO Q6H PRN for allergy symptoms (itching, rash, watery eyes, sneezing, runny nose, and nasal congestion). Do not exceed 300 mg in 24 hours. ***Consult doctor or nurse before giving if individual is taking psychotropic medications***

_____ 2. CONSTIPATION

Magnesium hydroxide (Milk of Magnesia) 400 mg. Take 30 mL PO Q12H PRN for constipation. Do not use for longer than 7 days without medical advice.
Sennoside + Docusate sodium (Senokot-S) 8.6/50 mg tablets. Take 2 tabs PO Q24H PRN for constipation. Do not use for longer than 7 days without medical advice.
Polyethylene glycol 3350 (Miralax) 17gm mix in 4-8 oz liquid once a day prn constipation. Do not exceed 3 days of use.

_____ 3. COUGH AND SORE THROAT

Cough drops. Use 1 cough drop PO Q2H PRN for cough. Do not exceed 8 drops in 24 hours.
Guaifenesin (Mucinex) 200 mg tab. Take 1-2 tablets every 4 hours PRN chest congestion.
Robitussin DM syrup. Take 10mL PO Q4H PRN for cough. Do not exceed 60 mL per day.
May substitute Robitussin Sugar-Free syrup for diabetes.

Initial: _____

GUEST NAME: _____ DOB: _____

_____ 4. DISCOMFORT/ MINOR PAIN

Acetaminophen (Tylenol) 325 mg tabs. Take 2 tabs PO Q4H PRN for minor pain and discomfort. Do not exceed 3,000 mg in 24 hours.
Ibuprofen 200 mg tabs. Take 2 tabs PO Q4H PRN for minor pain and discomfort. Do not exceed 3,200 mg in 24 hours.

_____ 5. FEVER
Acetaminophen (Tylenol) 325 mg tabs. Take 2 tabs PO Q4H PRN for oral temp >100.4° F. Do not exceed 3,000 mg in 24 hours.

_____ 6. GASTROINTESTINAL UPSET
Bismuth subsalicylate (Pepto-Bismol) regular strength. Take 30 mL PO Q1H PRN for diarrhea. Do not exceed 8 doses in 24 hours and do not take longer than 2 days.
Calcium Carbonate (TUMS) Chewable 500 mg. Take 2-4 tablets by mouth 4 times daily as needed for reflux /heartburn. Do not exceed 15 tabs in 24 Hours.
Maalox Oral Suspension. Take 10 mL PO Q6H PRN for indigestion, heartburn, and bloating. Do not exceed 4 doses in 24 hours.

_____ 7. INSOMNIA
Melatonin 2mg tab take 1, 2 or 3 tabs qhs for insomnia.

_____ 8. MINOR CUTS AND ABRASIONS
Antibacterial cream/ointment (Bacitracin). Apply pea-sized amount topically PRN Q8H for minor cuts and abrasions. **Check for allergies**
.

_____ 9. SKIN CONDITIONS
Hydrocortisone cream 1%. Apply topically to affected area Q6H PRN for irritation.
Calamine lotion. Apply topically to affected area Q2H PRN for itching.
Desitin. Apply topically Q4H PRN for diaper rash/incontinence.

_____10. NURSE'S DISCRETION
May give medications early or late at nurse's discretion.
May crush medications and give in applesauce, pudding etc. at nurse's discretion.
May check blood sugar PRN at nurse's discretion.

_____ 11. May substitute comparable generics for any of the above listed medications.

Physician Name:	
Physician Signature/Date:	

Medication Orders for Adult Crisis Therapeutic Home
Tel: 804-637-1305 Fax: 804-715-4083

GUEST NAME: _____ DOB: _____

Prescriptions, MAR or pharmacy printout signed by MD, NP, or PA acceptable as substitute for table below:

Medication Orders: (include both psychiatric and somatic medications. Add additional page/prescriptions as needed)

Medication	Dose	Route	Adm. Time	Reason Given
SARS-COV-2 Rapid Antigen Test (COVID 19)	one test	Nasal Swab	PRN Upon Admission	Resp Sx or Exposure

Physician Name:	
Physician Signature/Date:	

Virginia Tuberculosis (TB) Screening and Risk Assessment Tool

For use in individuals 6 years and older

Use this tool to identify asymptomatic **individuals 6 years and older** for latent TB infection (LTBI) testing.

- The symptom screen and risk factor assessment may be conducted by a licensed healthcare provider (MD, PA, NP, RN, LPN). If a symptom or risk factor for TB is identified, further evaluation should also be performed by a licensed healthcare provider (MD, PA, NP, RN, LPN), however an RN or an LPN conducting evaluations must have an order by healthcare personnel with prescriptive authority consistent with Virginia professional practice acts for medicine and nursing.
- Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment.
- A negative Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) does not rule out active TB disease.

First screen for TB Symptoms: ☐ None (If no TB symptoms present → Continue with this tool)

☐ Cough ☐ Hemoptysis (coughing up blood) ☐ Fever ☐ Weight Loss ☐ Poor Appetite ☐ Night Sweats ☐ Fatigue

If TB symptoms present → Evaluate for active TB disease

Check appropriate risk factor boxes below.

TB infection testing is recommended if any of the risks below are checked.

If TB infection test result is positive and active TB disease is ruled out, TB infection treatment is recommended.

☐ **Birth, travel, or residence in a country with an elevated TB rate ≥ 3 months**

- Includes countries other than the United States (U.S.), Canada, Australia, New Zealand, or Western and North European countries
- IGRA is preferred over TST for non-U.S.-born persons ≥ 2 years old
- Clinicians may make individual decisions based on the information supplied during the evaluation. Individuals who have traveled to TB-endemic countries for the purpose of medical or health tourism < 3 months may be considered for further screening based on the risk estimated during the evaluation.

☐ **Medical conditions increasing risk for progression to TB disease**

Radiographic evidence of prior healed TB, low body weight (10% below ideal), silicosis, diabetes mellitus, chronic renal failure or on hemodialysis, gastrectomy, jejunoileal bypass, solid organ transplant, head and neck cancer

☐ **Immunosuppression, current or planned**

HIV infection, injection drug use, organ transplant recipient, treatment with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact to someone with infectious TB disease at any time**

☐ **None; no TB testing indicated at this time**

Patient Name _____ Date of Birth _____/_____/_____

Name of Person Completing Assessment _____ Signature of Person Completing Assessment _____

Title/Credentials of Person Completing Assessment _____ Assessment Date _____/_____/_____

Adapted from California Tuberculosis Risk Assessment (www.ctca.org) & Colorado Tuberculosis Risk Assessment (www.colorado.gov) VDH TB 03/2023

Virginia Tuberculosis Screening and Risk Assessment User Guide

Symptoms that should trigger evaluation for active TB disease

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, poor appetite, weight loss, fatigue, and hemoptysis.

How to evaluate for active TB disease

Evaluate for active TB disease with a chest x-ray (CXR), symptom screen, and if indicated, sputum acid-fast bacilli (AFB) smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Negative test for TB infection does not rule out active TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease and poor outcome.

Avoid testing persons at low risk

Routine testing of low-risk populations is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Prioritize persons with risks for progression

Prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past 1 year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- low body weight (10% below ideal)
- history of chest x-ray findings suggestive of previous or inactive TB (no prior treatment). Includes fibrosis or non-calcified nodules, but does not include solitary calcified nodule or isolated pleural thickening. In addition to LTBI testing, evaluate for active TB disease.

U.S. Preventive Services Task Force recommendations

The USPSTF has recommended testing persons born in, or former residents of, a country with an elevated tuberculosis rate and persons who live in, or have lived in, high-risk Congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. USPSTF did not review data supporting testing among close contacts to persons with infectious TB or among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

Virginia Department of Health recommendations

This risk assessment has been customized according to the Virginia Department of Health's (VDH) TB Program recommendations. Providers should check with local TB control programs, or the VDH TB Program at (804) 864-7906 for local recommendations.

Mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations include: healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

Age as a factor

Age (among adults) is not considered in this risk assessment. However, younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger, non-U.S.-born persons when all non-U.S.-born are not tested. An upper age limit for testing has not been established but could be appropriate depending on individual patient TB risks, comorbidities, and life expectancy.

Virginia Tuberculosis Screening and Risk Assessment User Guide

Young children

This risk assessment tool is intended for individuals ≥ 6 years old. A risk assessment tool created for use in children < 6 years old can be found on the VDH website: https://www.vdh.virginia.gov/tuberculosis/screening-testing/

When to repeat a test

Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment. In general, this would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel in certain circumstances.

When to repeat a risk assessment

The risk assessment should be administered at least once. Persons can be assessed for new risk factors at subsequent preventive health visits.

IGRA preference in BCG vaccinated

Because the IGRA has increased specificity for TB infection in persons vaccinated with Bacillie Calmette-Guerin vaccine (BCG), IGRA is preferred over the TST in these persons. Most persons born outside the US have been vaccinated with BCG.

Previous or inactive tuberculosis

Chest radiograph findings consistent with previous or inactive TB include fibrosis or non-calcified nodules, but do not include a solitary calcified nodule or isolated pleural thickening. Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for TB infection. In addition to TB infection testing, evaluate for active TB disease.

A decision to test is a decision to treat

Emphasis on short course for treatment of TB infection

Shorter regimens for treating TB infection have been shown to be more likely to be completed and the 3-month 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug-resistant TB are typical reasons these regimens cannot be used.

Shorter duration TB infection treatment regimens

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + Rifapentine*	Weekly	12 weeks**
Isoniazid + Rifampin	Daily	3 months

*VDH recommends Directly Observed Therapy (DOT)

**11-12 doses in 16 weeks required for completion

Patient refusal of TB infection treatment

Refusal should be documented. Offers of treatment should be made at future encounters with medical services. Annual chest radiographs are not recommended in asymptomatic persons. If treatment is later accepted, TB disease should be excluded and CXR repeated if it has been > 3 months from the initial evaluation.

Region 4 REACH - Guest Profile

Name: _____ ID#: _____

Date Form Completed: _____

Basic Skills - Level of Assistance Required (check applicable column)

	Independent	Verbal Prompt	Gestured Prompt	Partial Physical	Full Assist	Description
Mobility						
Eating						
Drinking						
Bathing						
Oral hygiene						
Dressing						
Regulates water temperature						
Toileting (urine)						
Toileting (feces, wiping)						
Menstruation						
Fire Drill – Evacuation						
Street Crossing						
Telephone Use						
Money Skills						

Region 4 REACH Home Guest Profile

Behavior (check appropriate column)

	Appropriate	Occasional Problems	Frequent Problems	Description
Respects own clothing/ property				
Respects others' property				
Reaction to rules/ regulations				
Sexual behavior				
Temper				
Sleep habits				
Public restaurant				
Car				
Movies				
Stores, Malls, Crowds				
Picks up objects and places in mouth/ swallows				

Name: _____ ID#: _____

Region 4 REACH Home Guest Profile

1. Does guest have special issues to monitor? □Yes □No
If yes, explain:

_____

_____

2. Specific behavior problems:

_____

_____

_____

3. Describe the most effective ways to prevent or stop inappropriate behaviors from escalating:

_____

_____

_____

Communication/Social Skills

1. Describe how guest express needs (i.e. hunger, thirst, anger, sadness, happiness):

_____

_____

2. Describe socialization skills/style with each of the following (i.e. appropriate, quiet, talkative, assertive; indicate fears, likes, dislikes)

Family:_____ _____

_____

_____

Friends/Peers: _____

_____

Staff: _____

_____

Strangers: _____

_____

Daily Routine/Preferences

Describe a typical day in the individual's life including preferences:

A.M. Routine: _____

_____

Day Activities: _____

_____

P.M. Routine: _____

_____

Favorite Activities, Food, etc: _____

_____

Strong Dislikes/Stressors: _____

_____

Name: _____ ID#: _____

Region 4 REACH Home Guest Profile

Health Screening Questions

1. Check yes or no if the individual has been experiencing any of the below symptoms in the last 72 hours:

Symptom	Yes	No
Cough		
Sore throat		
Runny nose		
Fever		
Nasal or chest congestion		
Headache		
Diarrhea		
Vomiting		

2. If yes to any of the above, please describe and how long have the symptoms been present?

_____

_____

_____

****If any of these symptoms are present, the individual will be required to wear a mask in the home and distance from others until symptoms subside or they are cleared by our medical team.**

Print Name & Title of Person Completing Form:

_____

Signature of Person Completing Form:

_____

Date: _____

Name: _____ ID#: _____

Central Region REACH - Emergency Contacts Information

Name: _____ **ID#**: _____

Date of Birth: _____

Parent(s): _____

Day Phone #: _____ Evening Phone #: _____

Address: _____

_____

Email Address: _____

Legal Guardian (if applicable): _____

Day Phone #: _____ Evening Phone #: _____

Address: _____

_____

Email Address: _____

***For Adult CTH, must provide copy of legal paperwork before making decisions for individual**

Authorized Representative (if applicable): _____

Day Phone #: _____ Evening Phone #: _____

Address: _____

_____

Email Address: _____

***For Adult CTH, must provide copy of legal paperwork before making decisions for individual**

CSB/BHA: _____

Support Coordinator/Case Manager: _____

Day Phone #: _____ Evening Phone #: _____

Address: _____

_____

Email Address: _____

Central Region REACH - Emergency Contacts Information

Name: _____ ID#: _____

Emergency Contact (other than parent/guardian): _____

Day Phone #: _____ Evening Phone #: _____

Address: _____

_____

Email Address: _____

Preferred Hospital: _____

Phone Number: _____

Address: _____

_____

Primary Physician: _____

Phone Number: _____

Address: _____

_____

Neurologist: _____

Phone Number: _____

Address: _____

_____

Psychiatrist: _____

Phone Number: _____

Address: _____

_____

Central Region REACH - Emergency Contacts Information

Name: _____ ID#: _____

GI Specialist: _____

Phone Number: _____

Address: _____

_____

Dentist: _____

Phone Number: _____

Address: _____

_____

PBSF/ABA: _____

Phone Number: _____

Address: _____

_____

Email Address: _____

Intensive In-Home: _____

Phone Number: _____

Address: _____

_____

Email Address: _____

Outpatient Therapy: _____

Phone Number: _____

Address: _____

_____

Email Address: _____

Central Region REACH - Emergency Contacts Information

Name: _____ ID#: _____

School or Day Support Program: _____

Contact's Name: _____

Phone Number: _____

Address: _____

_____

Email Address: _____

Pharmacy: _____

Phone Number: _____

Address: _____

_____

Insurance Information

Policy Holder's Name: _____

Insurance Company: _____

Policy Number: _____

_____

Print Name & Title of Person Completing Form

_____ _____

Signature of Person Completing Form Date

Central Region REACH - Authorization for Medical Treatment
(To be completed by Guest and Guardian)

Guest Name:_____ ID#: _____

Date of Birth: _____

In the event that I _____(guest or guardian) cannot be reached, I hereby give consent for _____ (physician or medical facility) to provide medical care to undersigned guest for treatment of illness or injury.

If medication is prescribed, I hereby authorize: _____ (pharmacy name) at _____ (pharmacy address) to fill the prescription and charge my insurance. They can be contacted at _____ (phone number).

Policy Holder: _____

Insurance Name: _____

Policy Number: _____

_____ _____

Signature of Guest Date

_____ _____

Signature of Guardian or LAR Date

The above authorization is valid for one year from signed date.