Crisis Stabilization Unit (CSU) – Region IV – Admission Referral

A. PREADMISSION FACESHEET

1. PERSONAL INFORMATION

Name: _____ DOB: _____ Age: _____
First Middle Last

Address: _____
Street City State Zip code County

SSN: _____ Gender: _____ Race: _____ Hispanic origin? _____ Height _____ Weight _____

Phone: (____)_____ Marital status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse Name: _____ Military Status: _____ Start Year: _____ End Year: _____

Emergency Contact: _____ Relationship to Person: _____ Phone: (____)_____

Address: _____
Street City State Zip Code County

Employment Status: _____ Employer: _____ Phone: (____)_____

Education Level: (All ages) _____ Income: ☐ SSI ☐ SSDI ☐ Unknown

2. PREADMISSION SCREENING ENCOUNTER INFORMATION

Date: _____ Evaluation start time: _____ Evaluation end time: _____ Location: _____

Referral Source: _____ Evaluating CSB/BHA: _____ Consumer ID# _____

CSB of Residence: _____ CSB Code #: _____ Contacted?: ☐No ☐ Yes (_____)
Name Phone

CURRENT LOCATION: _____

3. INSURANCE INFORMATION

Insurance: ☐ Medicaid ☐ Medicare ☐ None ☐ Other: _____ ☐ Unknown

Primary plan # _____ If applicable, second plan #: _____

4. ELIGIBILTY CRITERIA: Must meet at least 2 of the following criteria

☐ Experiences difficulty in establishing or maintaining interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports.

☐ Experiences difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.

☐ Exhibits such inappropriate behavior that immediate interventions documented by mental health, social services, or the judicial system are or have been necessary.

☐ Exhibits difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate behaviors.

Reason for Referral/Summary of Presenting Crisis:

Summary of Psychosocial Stressors:

B. RISK ASSESSMENT DETAILS

1. SUBSTANCE USE ASSESSMENT & TREATMENT

☐ No current use reported ☐ No history of use reported ☐ Historical use *only* ☐ Declined to answer

Drug	Priority	Frequency & Amount	Method	Last Use Date & Amount	Age of 1st Use
	Primary				
	Secondary				
	Tertiary				

History of substance abuse ☐ (drugs, alcohol, mood altering substances, marijuana, prescription medications, inhalants)

Describe: _____

Have you or anyone else ever felt you had a drug or alcohol problem? ☐ Yes ☐ No

Have you previously received inpatient or outpatient SA treatment? ☐ Yes ☐ No

If yes: Maintenance Services ☐ Yes ☐ No Detoxification Services ☐ Yes ☐ No

Number of prior drug episodes? _____ ☐ Unknown

Name/Location of last treatment facility: _____ Date of discharge: _____

Withdraw Symptom	Current withdrawal symptom (last 24 hours)	History of withdraw symptom
Tremors	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Headaches	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Vomiting (Blood present) ☐ Yes ☐ No	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Nausea	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Diarrhea (Blood present) ☐ Yes ☐ No	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Sweating	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Paranoia	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
DT's	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Other	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Lab Results:

Blood alcohol level: _____ Toxicology screen: _____ ☐ Unable to Test

Tobacco use? ☐ Yes ☐ No ☐ Unknown

If yes: ☐ Smoke ☐ Chew ☐ Vape ☐ Unknown ☐ Other

Is the person pregnant? ☐ Yes ☐ No ☐ N/A

If yes: pregnant and using substances. ☐ Yes ☐ No

2. BEHAVIORAL HEALTH SERVICES & TREATMENT

Is the person currently in outpatient treatment? ☐Yes ☐ No ☐ Unknown

If yes: Name of facility/provider: _____

Case Manager: _____ Phone Number: _____

Psychiatrist: _____ Phone Number: _____

History of prior inpatient treatment? ☐Yes ☐ No ☐ Unknown

If yes: List most recent providers/facilities, type of treatment, and dates of service:

Provider or Facility	**Treatment type** (e.g., outpatient, inpatient, detox)	**Dates of service**

History of treatment…

Number of hospitalizations? _____ ☐ Unknown

In a state hospital? ☐ Yes ☐ No ☐ Unknown (name and date: _____)

In a crisis stabilization unit? ☐ Yes ☐ No ☐ Unknown (name and date: _____)

3. CURRENT SYMPTOMS AND MENTAL STATUS

Mental Status (Check all that apply)

Appearance	☐ WNL	☐ unkempt	☐ poor hygiene	☐ tense	☐ rigid	☐ other:
Motor	☐ WNL	☐psychomotor retardation	☐ psychomotor agitation	☐ tremor	☐ restless	☐ other:
Behavior	☐ WNL	☐ agitated	☐ guarded	☐ manic	☐ distracted	☐ impulsive
	☐ tearful	☐ easily startled	☐ other:			
Orientation	☐ WNL	☐ time disorientation	☐ place disorientation	☐ person disorientation	☐ situation disorientation	☐ other:
Speech	☐ WNL	☐ pressured	☐ slowed	☐ soft	☐ loud	☐ incoherent
	☐ slurred	☐ other:				
Mood	☐ WNL	☐ depressed	☐ angry	☐ hostile	☐ euphoric	☐ anxious
	☐ withdrawn	☐ anhedonic	☐ other:			
Affect	☐ WNL	☐ constricted	☐ blunted	☐ flat	☐ labile	☐ incongruent with situation
	☐ other:					
Thought Content	☐ WNL	☐impaired	☐unfocused	☐preoccupied	☐delusions	☐thought insertion
	☐ obsessions	☐grandiose	☐phobias	☐ideas of reference	☐paranoid	☐other:
Thought Process	☐ WNL	☐illogical	☐concrete	☐incoherent	☐tangential	☐perseverative
	☐impaired concentration	☐circumstantial	☐loose associations	☐flight of ideas	☐thought blocking	☐other:
Sensory	☐ WNL	☐ hallucinations type:_____		☐illusions	☐ flashbacks	☐ other:
Memory	☐ WNL	☐ impaired immediate		☐ impaired recent		☐ impaired remote
	☐other:					
Appetite	☐ WNL	☐ decreased	☐ increased	☐ weight loss	☐ weight gain	☐ other:
Sleep	☐ WNL	☐ insomnia	☐ onset problem	☐ maintenance problem	☐ hypersomnia	☐ other:
Insight	☐ WNL	☐ some	☐ little	☐ none	☐ blaming	☐ other:
Judgment	☐ WNL	☐ impaired	☐ poor	☐ other:		

Able to provide historical information? ☐ No ☐ Unknown ☐Yes (if yes, describe in Mental Status Narrative)
Reliability of self-report? ☐ Good ☐ Fair ☐ Poor ☐ Yes
Significant Clinical Findings (description of symptoms checked above):

Diagnosis (ICD-10); (P) for provisional, (H) for historical):

4. HEALTHCARE INFORMATION & MEDICAL HISTORY

Primary Care Provider: _____ Phone: _____ Date Last Seen: _____
Medical History and current medical issues or symptoms (☐ *If checked, see attached medical information*):

Current Medications: ☐ No ☐ Yes ☐ *If checked, see attached medication list*

Name	Dose	Schedule	Prescriber	Reason Prescribed

Does individual have a 7-day supply of all medications for admission? ☐ Unknown ☐ No ☐ Yes
Has individual followed recommended medication plan? ☐ Unknown ☐ No ☐ Yes
Has individual followed recommended recovery plan? ☐ Unknown ☐ No ☐ Yes
Recent medication change? ☐ Unknown ☐ No ☐ Yes Date & Describe:
Labs available? ☐ Unknown ☐ No ☐ Yes
Allergies(including food) or adverse side effects to medications: ☐ Yes ☐ No ☐ Unknown
If yes, explain:

5. LEGAL STATUS

Is individual on probation or parole? ☐ Unknown ☐ No ☐ Yes
If yes: Contact Name and Number:
Pending legal charges? ☐ Unknown ☐ No ☐ Yes
If yes: Describe charges:
Date of hearing: _____ ☐ Unknown
Has individual come from jail? ☐ No ☐ Yes

C. ADMISSION CRITERIA & TREATMENT PLANNING

1. INDIVIDUAL SERVICE PLANNING

Individuals who may be helpful in treatment planning:

Name	Telephone	Relationship

Name of individual: _____ will be contacted with information directly relevant to their involvement with the person's health care, including location and general condition.

☐ Family Member ☐ Legal Guardian

☐ Person agrees ☐ Person objects

2. CSU EXCLUSIONARY CRITERIA

☐ Lacks capacity to consent to treatment OR unwilling to participate in treatment
☐ Imminent danger to self/others
☐ Executable plan for suicide (at CSU)
☐ Actively violent/aggressive within last 24 hours
☐ Medically unstable (*see below*)
☐ Unable to manage ADL's
☐ Requires 1:1 monitoring
☐ Primary substance use disorder
☐ High Risk Sex Offense (review on case by case)
☐ No Exclusionary Criteria

3. CSU MEDICAL CLEARANCE CRITERIA

☐ Severe Burns (e.g. burns that cannot be cared for at home)
☐ Acute Delirium (not attributed to psychiatric cause)
☐ Altered Mental Status
☐ Over Dose (e.g. illegal substances or prescribed substances)
☐ Acute Pancreatitis
☐ Acute Head Trauma (e.g. fainting, unexplained falling, stitches to head)
☐ Unstable Fractures (open or closed); Joint Dislocations
☐ Seizure within 24 hours (e.g. prescribed seizure meds, reliably taking meds, using alcohol/drugs)
☐ Unexplained GI Issues (e.g. vomiting blood, severe diarrhea, pain)
☐ Bowel Obstruction (e.g. actively requiring treatment or observation)
☐ Acute Respiratory Distress (e.g. shortness of breath, chest pains, asthma attack within 24 hours)
☐ Acute Drug Withdrawal (history of DT's; BAC over 3.0; history of seizures during detox)
☐ Unstable Vital Signs
☐ Active GI Bleed
☐ Infectious Disease Requiring Isolation / Treatment by IV Antibiotics
☐ Draining Wound (e.g. open wound, requiring daily complex wound care)
☐ No Medical Clearance Criteria

4. CSU GOALS FOR TREATMENT

1.
2.
3.

5. DISCHARGE PLAN

_____ _____ _____

Evaluator Signature Date CSB/BHA

_____

Printed name (Not required if electronically signed)