Regional Forensic Psychiatric Center Preadmission Referral

In order to be considered a complete referral to the RFPC, and thus to be placed on the waiting list, the RFPC Preadmission Referral Form must be completed and asterisked items must be submitted at a minimum. All remaining documentation must be submitted for review prior to scheduling for admission.

Name: Last Name, First Name, and MI **Maiden Name**: Click here to enter text.

AKA: Click here to enter text.

Municipal or Common Pleas Court Number: Click here to enter text.

Home Address Prior to Incarceration: Address, City, State, Zip Code

☐ Male ☐ Female

SS#: Click here to enter text. **Marital Status**: Click here to enter text. **Religion:** Click here to enter text.

Date of Birth: Click here to enter text. **Age:** Click here. **Occupation**: Click here to enter text.

Veteran: ☐Yes ☐ No **Branch:** Click here to enter text.

Does the Person Speak English? ☐Yes ☐ No

Primary Language other than English: Click here to enter text.

Sensory Problems? ☐ Hard of Hearing ☐ Deaf ☐ Visual Impairment ☐ Blind

Level of Education: Click here to enter text. ☐ **New Admission** ☐ **Readmission**

Date of Last Discharge Click here to enter a date. **Unit:** Click here to enter text.

County of Residence: Click here to enter text. **Committing County:** Click here to enter text.

County of Sentence: Click here to enter text.

MH Commitment ***(check all that apply)*** ☐304 ☐304g2 ☐GBMI ☐305 ☐402 ☐403 ☐405

Other ***(Please clarify)*** Click here to enter text.

Most Recent MH Commitment Date: Click here to enter a date.

Effective Date: Click here to enter a date. **Duration:** Click here to enter text.

Reason for Referral as Written on the Court Order:

Click here to enter text.

Charges: Click here to enter text.

Date of Incarceration: Click here to enter a date.

Is Person Currently Sentenced? ☐Yes ☐ No **Max Out Date:** Click here to enter a date.

Anticipated Court Date: Click here to enter a date.

Judge: Click here to enter text. **Phone Number:** Click here to enter text.

Defense Attorney: Click here to enter text. **Phone Number**: Click here to enter text.

Medical Department Contact: Click here to enter text. **Phone Number**: Click here to enter text.

Community Behavioral Health Contact: Click here to enter text. **Phone Number**: Click here to enter text.

Base Service Unit/Service Coordination Unit Prior Mental Health Services: ☐ Yes ☐ No If Yes, Click here to enter text.

Name: Click here to enter text.

Phone Number: Click here to enter text. **Work:** Click here to enter text. **Cell:** Click here to enter text.

Date Behavioral Health Notified of Referral to RFPC: Click here to enter a date.

Psychiatric/Medical Diagnosis (es) – *Please enter all know conditions*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.

Reason for Incompetency if Found Incompetent: Click here to enter text.

High Risk Behavior *(Past/Present)*

☐ Suicide Attempt(s); Date(s); Method(s): Click here to enter text.

☐ AWOL History ☐ Self-Mutilative ☐ Homicidal

☐ Anorexic ☐ Self-Abusive ☐ History of Fire Setting

☐ Polydipsia ☐ Assaultive/Destructive ☐ Sexually Aberrant Behavior

☐ PICA ☐ Uncontrolled Seizure Disorder

Other (Please be specific): Click here to enter text.

Current Medications *(Psychiatric & non-psychiatric)* List below or attach MAR.

Is MAR attached? ☐ Yes ☐ No

Name Of Medication	Dosage	Reason for Medication	Start Date	Takes Meds Yes/No

Name: Click here to enter text.

Over the Counter Medication or Herbal Supplements: Click here to enter text.

Drug Allergies *(Specific Reaction)*: Click here to enter text.

Food Allergies *(Specific Reaction)*: Click here to enter text.

Special Diet: Click here to enter text.

Environmental Allergies: Click here to enter text.

Physical Problems *(Including injury (ies); chronic pain; sensory limitation or others as noted):*
Click here to enter text.

Any current/acute/chronic infectious disease: ☐Yes ☐ No
If yes, explain: Click here to enter text.

Ambulation: ☐ Unaided ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Prosthesis
Specify: Click here to enter text.

Immunizations (Include PPD) List Below or Attached ☐Yes ☐ No	**Date Administered**

Recent Psychological Tests: ☐ Yes ☐ No *Date of Report:* Click here to enter a date.

Prior Psychiatric Hospitalizations:

Location	**Dates**

Drug, alcohol and nicotine history: Click here to enter text.

Drug, alcohol and nicotine treatment history: Click here to enter text.

Advanced Directives: *Medical:* ☐Yes ☐No *Psychiatric:* ☐Yes ☐ No

Organ Donor: ☐Yes ☐No

Income: ☐Yes ☐No *Source:* Click here to enter text. *Amount:* Click here to enter text.

Medical Insurance Information: Click here to enter text.

Name: Click here to enter text.

Medical Assistance Number: Click here to enter text. **Medicare Number:** Click here to enter text.

Medicare D Plan: Click here to enter text. **ID:** Click here to enter text.

Next of Kin/Significant Others:

(1) Name: Click here to enter text. Relationship: Click here to enter text.

Address: Address, City, State, Zip Code

Phone: Home Phone: Work Phone: Cell

(2) Name: Click here to enter text. Relationship: Click here to enter text.

Address: Address, City, State, Zip Code

Phone: Home Phone: Work Phone: Cell

The Following Documentation is required

1. *Affidavit of Probable Cause ☐ *Criminal Complaint ☐ *Police Arrest Record ☐
2. * Court Order ☐
3. Sentencing Sheet ☐
4. Copies of Assessments:

*Psychiatric	☐Included	☐Not Included/Reason Click here to enter text.
Nursing	☐Included	☐Not Included/Reason Click here to enter text.
*Medical	☐Included	☐Not Included/Reason Click here to enter text.
Psychological testing	☐Included	☐Not Included/Reason Click here to enter text.
Psycho-social	☐Included	☐Not Included/Reason Click here to enter text.
Competency Evaluation	☐Included	☐Not Included/Reason Click here to enter text.
Other Disciplines involved in patient's care	☐ Included	☐Not Included/Reason Click here to enter text.

5. Copies of reports:
   - ☐ Consultations
   - ☐ Laboratory Reports and/or other medical studies performed including
   - ☐ Chest x-ray; EKG; EEG; HIV; Hepatitis; TB; CBC; SMAC; WBC; PPD
   - ☐ Medication related blood levels
6. *Copies of Progress notes and Physician's Orders for at least the last three weeks ☐
7. Copy of current Treatment Plan ☐
8. Certificate of Need Attached if under age 22 or 65 and above? ☐Yes ☐ No

Signature of Person Completing the Form: _____ Date: Click here to enter a date.

Printed Name/Title: Click here to enter text. Phone Number: Click here to enter text Email: Click here to enter .

Please fax completed referral to: Click here to enter text.

Or via encrypted email completed referral to: Click here to enter text.

At email address: Click here to enter text.

Attachment 4

CERTIFICATION OF NEED FOR
INPATIENT PSYCHIATRIC HOSPITALIZATION OF A
PERSON UNDER THE AGE OF 22 OR OVER THE AGE OF 65

Date: _____

The undersigned members of the Psychiatric Treatment Team at the

_____ hereby certify that
(Name of Referring Agency)

_____, requires psychiatric treatment on an
(Patient)

inpatient basis. We have examined said patient and find that:

1. The ambulatory care resources in the community do not meet the needs of the patient; and

2. Inpatient treatment under the direction of a physician is required; and

3. The provision of such services can reasonably be expected to improve the patient's condition or to prevent further regression so the services will no longer be needed.

_____	_____
Psychiatrist/Physician	Name & Title
_____	_____
Psychologist	Name & Title
_____	_____
Social Worker, Registered Nurse or Occupational Therapist	Name & Title

Ref. Authority 42 C.F.R. 441, Subpart D.

Attachment 5

pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Date:

To: _____
(Referring Person and Agency)

The RFPC Referral and/or Court Order for the Admission of _____
(circle one) *(Name)*
to the RFPC was received on _____.
(Date)

In order to assure complete and thorough evaluation of the referral, in addition to adequately addressing any medical concerns or safety/security measures related to the individual, the following items that were not included must still be provided:

_____ The Court Order

_____ RFPC Referral Form Information: _____

_____ Affidavit of Probable Cause

_____ Criminal Complaint

_____ Police Arrest Record

_____ Assessments: _____ Psychiatric Evaluation _____ Nursing _____ Medical
_____ Psychological testing _____ Psycho-Social

_____ Competency Evaluation

_____ Other Assessments/Screens: _____ Laboratory Reports _____ Chest X-Ray
_____ Hepatitis Screen _____ HIV Test
_____ Medication Related Testing _____ PPD

_____ Medication Administration Record

_____ Progress Notes *(for at least weeks)*:_____

_____ Current Treatment Plan

_____ Certificate of Need under age 22 or 65 and over

Once the specified materials are received the individual will be placed on the RFPC wait list for admission. The materials may be submitted electronically, mailed or personally delivered to the attention of: _____. Please direct all questions to
(Name)
_____, at _____ or via email at _____
(Name) *(Phone number)* *(email address)*

Sincerely,

_____, *CEO*