



Highland Rivers Community Service Board
Child and Adolescent Crisis Stabilization Program
 Location: 705 North Division Street Building 315
 Rome, GA 30165
 Mailing Address: P. O. Box 2968 Rome, Ga. 30164
 Phone #: 706-802-5870 Fax #: 706-802-5921

For Child and Adolescent Crisis Stabilization Program Staff use only:
 Date of referral: _____ Time: _____
 _____ Met criteria for referral
 _____ Did not meet criteria for referral
 Why? _____

 Signature of Child and Adolescent Crisis Stabilization Program Staff receiving referral: _____

Pre-Admission Referral Form

Date: _____ Time: _____ Referring Facility/Agency: _____ Type of Agency/Facility: _____
 Name of Agency Staff Making Referral: _____ Phone #: _____ Fax#: _____

IDENTIFYING INFORMATION

Consumer Name: Last: _____ First: _____ Middle: _____
 Sex: _____ Race: _____ DOB: _____ Age: _____ SS#: _____
 Aliases / Recent Name Changes? (e.g.: adoption) _____
 Consumer's Current Address: _____ City: _____ State: _____ Zip: _____
 Home Phone Number: _____ County of Residence: _____
 Insurance: (check one) () Medicaid #: _____ () CMO Medicaid Specify: _____
 () Private: Policy Name/#: _____ () Non-Insured

Religion: _____ Primary Language: _____ Language Barrier: _____

Parent/Legal Guardian Name: _____ Relationship: _____ Phone: _____

Parent/Legal Guardian Address (if different from consumer): _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Current Living Situation: ___ Hospital ___ Group Home ___ RYDC/Detention ___ W/Family ___ Foster Home/Care ___ DEFCS Custody
 ___ Medicaid Waiver Home ___ DD Placement

Other Agencies involved with the consumer:

Agency: _____ Staff Name: _____ Phone: _____
 Agency: _____ Staff Name: _____ Phone: _____

HIGH RISK HISTORY:

___ Suicidal ___ Elopement Risk ___ Sexually Aggressive ___ Physically Aggressive ___ Eating Disorder ___ Fire Setting ___ Medical Issues
 ___ Self Harm Explain: _____

REASON FOR REFERRAL

(Describe the Reporting Mental Health/Substance Abuse Problems/Causes and Onset and need for Crisis Stabilization.)

DSM IV Diagnosis Axis I: _____ DSM IV Diagnosis Axis II: _____

Diagnosis Axis III: _____ DSM IV Diagnosis Axis IV: _____

History of Psychiatric Hospitalizations (Dates/Where): _____

Previous Treatment Facility/Provider: _____ When Treated: _____

Does the consumer have a Primary or Secondary Mental Retardation Diagnosis? ___ YES ___ NO
 If yes, ___ Mild ___ Moderate ___ Severe Overall IQ Score: _____

Consumers cannot be admitted to The C&A CSP with a Primary Diagnosis of the following:
Mental Retardation, Autism or Traumatic Brain Injury

Does the consumer have a history of head injury? YES NO **If yes, when?** _____ Please describe the residual effect: _____

Current Mental Health /Behavioral/Substance Abuse /Legal Problems

Suicidal Threats/Gestures / Plan. within past 7 days (Circle One) What was the Threat/ Gesture/ Plan _____

Hallucinations within past 7 days: () Tactile () Auditory () Visual (Describe): _____

High Risk Behaviors within past 36 hours () Homicidal Threats/Gestures/Plan () Self Destructive Behavior () Destruction of Property () Sexual Acting out () Paranoia () Self Harm (Describe all/any) _____

Legal Issues: Is the child currently on Probation/Court Supervision? (Circle) (Describe any current felony level or misdemeanor level charges): _____

CURRENT ALCOHOL /DRUG USE:

Alcohol/Drug Use within past 7 days: () Methamphetamine Use () Alcohol Abuse /Dependence () In withdrawal () History of Blackouts () Drug Abuse/Dependence Blood Alcohol Level: _____ **(Please send UDS)**

Name of Alcohol or other drugs abusing including Prescription Medications and Over-the-Counter Medications:							
Drug Taken	Amount	Frequency	Last Taken	Drug Taken	Amount	Frequency	Last Taken

DISCHARGE PLANS

Is the Consumer able to return to current home/placement? Yes No **If yes, when?** _____ **If no, why not?** _____

What is the discharge plan? _____

MEDICAL HISTORY

Allergies: _____ **Vital Signs:** _____ **Temp:** _____ **Ht:** _____ **Wt:** _____
 Asthma Diabetes Enuresis Encopresis Seizures Eating Disorder other: _____
 Medical/physical problems or limitations? [] Yes [] No Explain: _____
 Recent Illness? Explain: _____
 Is Consumer PREGNANT: Yes No Unknown

If the answer to any of the following questions is yes, usually the consumer is **inappropriate** for the level of care at a BHDD Crisis Stabilization Unit. The consumer will require further evaluation and discussion.

Does the consumer....?	Yes	No	Explain
Require highly specialized medical services, or high acuity nursing care?			
Require further evaluation of acute care of severe asthma or diabetes?			
Have infections/contagious diseases (e.g. TB, measles, MRSA, etc) or wound requiring isolation or procedures to prevent transmission?			
Have an acute overdose and may be medically unstable?			

CURRENT MEDICATIONS: (Prescribed and Over-the-Counter)

Name	Dosage	Frequency	Last Taken

Please Fax Labs and/or Drug Screens

Signature of Referring Staff completing the form: _____ **Printed Name:** _____

****Medically Cleared by (Physician's Signature):** _____ **Printed Name:** _____

Physician's Signature Signifies Medical Clearance

Please FAX this completed form and other requested information to: (706) 802-5921. If you have questions, please call (706) 802-5870.