WEST SPRINGS *hospital*

Psychiatric Care & Recovery

REFERRAL REQUEST

Date: _____ **Time:** _____

1. **Name of Patient:** _____ **DOB:** _____ **Age:** _____

Parent/Guardian: _____ **PHONE #** _____

Status: ☐ M1 Date: _____ Time: _____ ☐ M8 ☐ M9 ☐ Vol ☐ Detainer

Gender Identity: ☐ Male ☐ Female ☐ Other:

2. **Precipitating Event(s):** _____

_____

_____

3. **Psychiatric Disorder to be Treated:** Ex.: Psychosis, Schizophrenia, Severe Depression, ETC.

_____

_____

4. **Concerns driving Hospitalization:** Ex.: Suicidal, Violence, not caring for self, withdrawal, ETC. (Explain)

_____

_____

5. **Have Less-Restrictive Option been Considered:** Ex.: Outpatient Services, Peer Support, Detox, ETC. (Explain)

_____

6. **Medical Concerns; Acute or Chronic:** Ex.: Pregnant, Seizures, Diabetes, CHF, COPD, ETC.

_____

Allergies: _____

7. **Does patient require:** Cardiac or EEG monitoring, NG Tube, O2, CNA for assistance or any other nursing interventions: ☐ Yes ☐ No If yes, explain: _____

_____

8. **Violent Behaviors Exhibited:** ☐ Yes ☐ No If yes, explain: _____

_____

Referral Source – Organization Name: _____

Referral Source Contact Person: _____

Contact Phone Number: _____

Nurse to Nurse Number: _____

Doctor to Doctor Number: _____

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REFERRAL – MEDICAL CONDITION OF PATIENT

M	Medical concerns present	(e.g., pregnant, CHF, seizures, septicemia, IDDM, ESRD, active bleeding, severe pain, arrhythmias, wounds, head injuries, sutures, etc.)	☐ No	☐ Yes
E	Examination of vitals and orientation abnormal	a. T > 38.0 b. HR < 50 or > 110 c. SBP < 100 or > 220 d. RR < 8 or > 22 e. SaO2 < 90 f. Cannot answer name, location, month/year	☐ No	☐ Yes
D	Drugs that require monitoring or **could be** an overdose concern	(e.g., lithium, warfarin, digoxin, phenytoin)	☐ No	☐ Yes
I	Ingestion (evidence of or recent OD, accidental ingestion, toxicity) or Inebriation (to the extent that cannot answer name, location, month/year) or I.V. or catheters needed		☐ No	☐ Yes
C	CNA needed or Condition changed quickly	(e.g., help with ambulation/washing/toileting) or (e.g., found down, mental status abruptly declined, CVA, seizure, encephalopathy)	☐ No	☐ Yes
A	Age (<12 or > 75)		☐ No	☐ Yes
L	Laboratory monitoring is likely needed	(e.g., dropping hematocrit, acetaminophen levels, INR, EKG monitoring, 24 hour EEG)	☐ No	☐ Yes
If **Yes*** to any MEDICAL items, please summarize specific evaluation(s)/treatment(s) needs to maintain stability in psychiatric hospital in the space below:				
If the patient is currently on any medication, please list them below with the following format; ***Medication name, dose, frequency***:				

WSH ADMISSIONS PHONE: 970-201-4299

WSH ADMISSIONS FAX: 970-683-7279

WSH ADMISSIONS EMAIL: WSH_REFERRALS@WESTSPRINGSHOSPITAL.ORG