Highland Hospital Referral Form

Caller Name: _____ **Relationship to Patient**: _____ **Phone #**:_____

Agency/Hospital: _____ **Phone #**_____ **Title**: _____

Patient Name: _____ **Age**:____ **DOB**:__/__/____ **SS#:** ____-_____-____ **[Male] [Female][Trans]**

Address: _____ **County**: _____ **Phone #**:_____

Guardian/POA: _____**Phone #**: _____ **Guardian Relationship to Patient: _____**

DHHR CPS / APS Involvement: [Yes] [No] **If Yes, Worker Name / County**: _____

Living Arrangements: _____ **Is patient able to return:** [Yes] [No]

Presenting Issue:

_____

_____

_____

Suicidal Ideations: [Yes] [No] **Suicidal Plan** [Yes] [No] **If yes, please explain**: _____

Have you ever attempted suicide? [Yes] [No] **If yes, when was the most recent attempt**? _____

Homicidal Ideations: [Yes] [No] **Hx of Violence/Aggression**: [Yes] [No] **Current Behavior**: _____

Current Legal Charges: [Yes] [No] **Currently on Probation / Parole:** [Yes] [No] **If Yes, What County?_____**

Sexually Inappropriate Behavior: [Yes] [No] **Sex Offender Status:** [Yes] [No]

Psychosis: [Yes] [No] **If yes, please explain**: _____

Previous Inpatient Psychiatric Care: [Yes] [No] **If yes, where and when:_____**

MR/IDD/Autism/Fetal Alcohol: *Circle all that apply* **IQ**: _____

Substance Abuse: [Yes] [No] **Drug of choice:** _____ **Frequency**:_____

Date of last use: _____ **Current Withdrawal Symptoms**: _____

Current Medications:_____

Medical Concerns: _____

Completes ADLs Independently: [Yes] [No] **Walks Independently:** [Yes] [No]

Allergies: _____

Hx of MRSA: [Yes] [No] **If yes, Did patient have MRSA in last 12 months**? [Yes] [No]

Insurance: _____ **Policy #:** _____

Policy Holder: _____

Please Fax this referral and any available additional information (Demographics, H&P, Labs, Radiology) to 304-760-5122. If you have any questions, please contact Highland Hospital Intake at 304-926-1600, Option 1.