Admission Form

Phone: 1-855-802-7095 **Fax: 1-855-268-9392**

Member Demographics			
Last Name Click here to enter text.	First Name Click here to enter text.	MI ___	Beneficiary ID: Click here to enter text. Admission Date: Click here to enter a date.
Completed by: Click here to enter text.			Admission TIME: ___ ☐AM ☐PM
Date of birth: Click here to enter a date.	Age: ___ Gender: ___		Telephone #: Click here to enter text.

Address/Street	Apt. #	City	County	State	Zip
Click here to enter text.	___	Click here to enter text.	Click here to enter text.	KS	Click here to enter text.

Other Health Insurance? ☐Yes ☐ No If yes specify:
CMHC Responsibility: Choose an item.
Member Status: Choose an item.

Admission Type: ☐Acute ☐PRTF ☐State Hosp Alt ☐Wheatland ☐ Prairie Ridge ☐State Hospital

Facility Name: Click here to enter text.

Address/Street	City	State	Zip
Click here to enter text.	Click here to enter text.	KS	Click here to enter text.

Facility ID: Click here to enter text.	Facility NPI #: Click here to enter text.
Facility telephone #: Click here to enter text.	Fax #: Click here to enter text.
Attending Physician name: Click here to enter text.	Telephone #: Click here to enter text.
Facility UM Reviewer: Click here to enter text.	Telephone #: Click here to enter text.

Admission Assessment ☐ Voluntary ☐ Involuntary

Circumstances of admission: (Outpatient referral, ER, MFT, transfer from ICU, Medical, self-referral, other)
Click here to enter text.

Specify current symptoms and behaviors that require hospitalization:
Click here to enter text.

Results of lethality assessment: (describe current plan and level of intent)
☐Suicide Ideation ☐Active SI ☐Passive SI
☐Homicidal Ideation ☐Active HI ☐Passive HI
Means to carry out plan: Click here to enter text.

Member's current frame of mind: (feeling justified in attempt, disappointment in failed attempt, etc.)
Click here to enter text.

Current Legal Status

Currently on Supervision: ☐Yes ☐ No If yes specify:
Custody: Choose an item.
Name of Contractor: Click here to enter text.
Dates of Custody: From: Click here to enter a date. To: Click here to enter a date.

OPTUMHealth™

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Current

Current Mental status exam: (Current symptoms of distress or dysfunction, appearance, behavior, orientation, thought process/content, affect mood, memory, psycho motor status, judgment, impulse control, etc.)
Click here to enter text.

Current Services: Click here to enter text.

Current living arrangement, support system, psycho social stressors, history of abuse/trauma:
Click here to enter text.

Historical

Previous SI/HI attempts: Click here to enter text.

History of prior inpatient psychiatric hospitalizations: Click here to enter text.

Substance Use

Is substance abuse a contributing factor: ☐Yes ☐No Explain:

Vital Signs: BP: ____ Temp: ____ Resp: ___ Pulse: ___

Current Psychotropic medications	Dosage	Schedule	Route	Start Date

Med Compliant: ☐Yes ☐No
Labs: Click here to enter text.

DSM Diagnostic Impressions

Primary: Click here to enter text.

Secondary: Click here to enter text.	Other: Click here to enter text.
Other: Click here to enter text.	Medical Issues: Click here to enter text.

Special Population: ☐SED ☐SPMI ☐SMI ☐IDD
☐Pregnant using substances ☐BH and SUD ☐BH and IV user

Treatment Objectives: Click here to enter text.

Discharge plan: Click here to enter text.

Expected length of stay: Click here to enter text.

Provider signature: _____ **Credentials:** _____ **Date:** _____