

Admission Form

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

Member Demographics					
Last Name <small>Click here to enter text.</small>	First Name <small>Click here to enter text.</small>	MI ___	Beneficiary ID: <small>Click here to enter text.</small>		
Completed by: <small>Click here to enter text.</small>			Admission Date: <small>Click here to enter a date.</small>		
Date of birth: <small>Click here to enter a date.</small>		Age: ___	Gender: ___	Admission TIME: ___ <input type="checkbox"/> AM <input type="checkbox"/> PM	
Address/Street <small>Click here to enter text.</small>		Apt. # ___	City <small>Click here to enter text.</small>	County <small>Click here to enter text.</small>	State KS
Zip <small>Click here to enter text.</small>					
Other Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes specify:</small> CMHC Responsibility: Choose an item. Member Status: Choose an item.					
Admission Type: <input type="checkbox"/> Acute <input type="checkbox"/> PRTF <input type="checkbox"/> State Hosp Alt <input type="checkbox"/> Wheatland <input type="checkbox"/> Prairie Ridge <input type="checkbox"/> State Hospital					
Facility Name: <small>Click here to enter text.</small>					
Address/Street <small>Click here to enter text.</small>		City <small>Click here to enter text.</small>		State KS	Zip <small>Click here to enter text.</small>
Facility ID: <small>Click here to enter text.</small>			Facility NPI #: <small>Click here to enter text.</small>		
Facility telephone #: <small>Click here to enter text.</small>			Fax #: <small>Click here to enter text.</small>		
Attending Physician name: <small>Click here to enter text.</small>			Telephone #: <small>Click here to enter text.</small>		
Facility UM Reviewer: <small>Click here to enter text.</small>			Telephone #: <small>Click here to enter text.</small>		
Admission Assessment <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary					
Circumstances of admission: (Outpatient referral, ER, MFT, transfer from ICU, Medical, self-referral, other) <small>Click here to enter text.</small>					
Specify current symptoms and behaviors that require hospitalization: <small>Click here to enter text.</small>					
Results of lethality assessment: (describe current plan and level of intent) <input type="checkbox"/> Suicide Ideation <input type="checkbox"/> Active SI <input type="checkbox"/> Passive SI <input type="checkbox"/> Homicidal Ideation <input type="checkbox"/> Active HI <input type="checkbox"/> Passive HI Means to carry out plan: <small>Click here to enter text.</small>					
Member's current frame of mind: (feeling justified in attempt, disappointment in failed attempt, etc.) <small>Click here to enter text.</small>					
Current Legal Status					
Currently on Supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes specify:</small> Custody: Choose an item. Name of Contractor: <small>Click here to enter text.</small> Dates of Custody: From: <small>Click here to enter a date.</small> To: <small>Click here to enter a date.</small>					

Admission Form

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

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: <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:				
Vital Signs: BP: _____ Temp: _____ Resp: _____ Pulse: _____				
Current Psychotropic medications	Dosage	Schedule	Route	Start Date
Med Compliant: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> SED <input type="checkbox"/> SPMI <input type="checkbox"/> SMI <input type="checkbox"/> IDD <input type="checkbox"/> Pregnant using substances <input type="checkbox"/> BH and SUD <input type="checkbox"/> 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: _____