Southern Highlands CMHC Crisis Response Unit

Referral Form Information & Instructions

To make a referral to the Crisis Response Unit (CRU) please complete the referral form and Mail, fax, or e-mail (preferred) the completed referral packet and requested items to: Southern Highlands CMHC 200 12th St. Ext. Princeton WV, 24740, Fax: 304-487-1512 or e-mail: cru@shcmhc.com. Failure to complete all sections and provide adequate information upon making a referral will delay the decision making process and may lead to the denial of crisis services. If you have, any questions please feel free to call (681) 282-5605 or 304-425-9541 ext. 1329

How the process works

- The CRU is voluntary only. At any time, if the person wishes to leave or the guardian decides that they can leave then arraignments will need to be made to discharge the person.
- The Southern Highlands CMHC CRU is for Adults Only.
- Families without a service provider will need to complete the referral packet to the best of their ability. The CRU will assist the family as needed with obtaining information and filling out the referral packet.
- Referrals from Hospitals and Adult Protective Services must complete the referral packet to the best of their abilities. CRU services are only available to adult individuals who have a diagnosis of an Intellectual and/or Developmental Disability. Proof of this must be submitted with the referral packet.
- Individuals who receive Title XIX Waiver services or ICF/IID services must have a team meeting to discuss accessing CRU services. CRU services must be a team based decision.
- Once the team has agreed to access CRU services then a referral to the CRU can be completed.
- Once the referral has been completed and sent to Southern Highlands CMHC our review team will look over the referral packet to make sure that it is completed and that all requested documentation has been provided. If any information is lacking the CRU will then send a request for the additional information. This may delay the review process.
- The review team will review all the information to determine if the CRU can provide services to the individual. Several factors are considered in making this decision. These include but are not limited to the following:
  - Can the site meet the person's needs?
  - Can the site assure the safety of the person and other residents?
  - Is there an appropriate discharge plan.
- Once a decision has been made a member of the review team will contact the person making the referral and inform them of the decision. If the referral is accepted the admission process begins and additional documentation from the CRU will need to be completed prior to admission. If the referral is declined then the CRU Resource Coordinator will work with the referring party to find alternate placement or assist in developing a plan to keep the person safe and in their current setting.
- As part of the admissions process CRU supervisor will work to set an admission date with the referring person/agency. Follow up meetings including a 72 hour meeting, 7 day meeting, and discharge meeting date will be set as will the date of discharge.

Instructions for completing the referral form

- Be sure to complete all sections of the referral form to the best of your ability.
- Do not write, "See attached" in any section. Fill in the requested information on the referral form.
- Provide as much detail as possible. The review team does not know the client and will make its decision based on the documentation provided.
- If the referral is hand written, make sure that your writing is legible. Do not white out any mistakes, instead draw one single line through the mistake and initial by the mistake.

Southern Highlands CMHC Crisis Response Unit

Referral Form

Person/Agency Making the referral

Agency: ______________________ Date: __________

Name: ______________________ Phone#: __________

E-mail: ______________________ Fax#: __________

Client Demographics

Client Name: ______________________ Date of Birth: __________

Address: ______________________ Phone Number: __________

____

County: ______________________ Social Security #: __________

Gender: Male ☐ Female ☐ Ethnicity: __________ Age: __________

Living situation: ☐ Natural Family, ☐ I/DD Waiver ISS, ☐ ICF/IID, ☐ Specialized Family Care Provider, ☐ Other

CRU Services Requested

Traditional CRU Services ☐ CRU with Psychiatric Coverage ☐ Resource Coordination ☐ PBS ☐

Guardianship Status

Check which one applies

☐ Self, ☐ Full Guardian, ☐ Limited Guardian, ☐ Health Care Surrogate, ☐ Medical Power of Attorney

Name: ______________________ Home Phone: __________

Address: ______________________ Cell Phone: __________

____

* If the person has a guardian, healthcare surrogate or medical power of attorney then copies of the documentation must be provided to Southern Highlands CMHC as part of the referral packet.

Medley Advocate ☐ Yes, ☐ No

Agency: ______________________ Phone#: __________

Name: ______________________ Other #: __________

E-mail: ______________________ Fax#: __________

Service Coordinator/Case Manager

Agency: ______________________ Phone#: __________

Name: ______________________ Other #: __________

E-mail: ______________________ Fax#: __________

Referral Form

Behavior Support Professional			
Agency:		Phone#:	
Name:		Other #:	
E-mail:		Fax#:	

RN (If they receive nursing services)			
Agency:		Phone#:	
Name:		Other #:	
E-mail:		Fax#:	

Funding Source (Check all that apply)		
☐ Title XIX Waiver	☐ Medicaid	☐ Medicare
☐ Private Pay	☐ Other:	☐ No Funding source

Reason for Referral

Discharge Plan

*Every person who is referred to the CRU must have a discharge plan.

Diagnosis	
DSM-V Diagnosis with codes	**Medical Diagnosis**

Referral Form

Client Daily Living Skills

Toileting	
Can toilet independently	☐ Yes ☐ No
Requires some assistance	☐ Yes ☐ No
*Uses adult briefs	☐ Yes ☐ No
Menses Care	☐ Yes ☐ No
Schedule needed	☐ Yes ☐ No
Can sit on toilet	☐ Yes ☐ No
Can indicate need	☐ Yes ☐ No

Bathing	
Is able to stand in shower	☐ Yes ☐ No
Can bath them selves	☐ Yes ☐ No
Needs assistance with bathing	☐ Yes ☐ No
Can use a washcloth	☐ Yes ☐ No
Can use Soap	☐ Yes ☐ No
Can use shampoo	☐ Yes ☐ No
Can use a towel	☐ Yes ☐ No

Communication	
Verbal (Can make needs known)	☐ Yes ☐ No
Verbal (Has some difficulties)	☐ Yes ☐ No
Non-verbal	☐ Yes ☐ No
Uses sign language	☐ Yes ☐ No
Uses gestures to communicate	☐ Yes ☐ No
Unable to make needs known	☐ Yes ☐ No

Sexuality Information	
Sexually aggressive	☐ Yes ☐ No
Masturbates	☐ Yes ☐ No
History of inappropriate activity	☐ Yes ☐ No
Exposes self to others	☐ Yes ☐ No
Attempts to see others naked	☐ Yes ☐ No
Talks about sex frequently	☐ Yes ☐ No

Eating	
Feeds self	☐ Yes ☐ No
Needs to be fed by staff	☐ Yes ☐ No
Uses utensils	☐ Yes ☐ No
Adaptive utensils used	☐ Yes ☐ No
Can drink independently from cup	☐ Yes ☐ No

Eating cont.	
Does food need to be chopped	☐ Yes ☐ No
Does food need to be pureed	☐ Yes ☐ No
Attempts to eat to fast	☐ Yes ☐ No
Needs liquids thickened	☐ Yes ☐ No
Swallowing issues	☐ Yes ☐ No

Oral Hygiene	
Able to brush teeth independently	☐ Yes ☐ No
Has/uses dentures	☐ Yes ☐ No
Able to care for dentures	☐ Yes ☐ No
Able to use toothbrush	☐ Yes ☐ No
Able to apply toothpaste	☐ Yes ☐ No
Needs total oral care	☐ Yes ☐ No

Dressing	
Needs assistance to dress self	☐ Yes ☐ No
Independently put on pants	☐ Yes ☐ No
Independently put on shirt	☐ Yes ☐ No
Independently put on underwear	☐ Yes ☐ No
Independently put on socks	☐ Yes ☐ No
Independently put on bra	☐ Yes ☐ No

If the Client uses adult briefs then indicate usage.			
Wear them 24/7 ☐	During the day only ☐	Night time only ☐	Outings only ☐

*Consumers will need to bring enough personal care items such as feminine products, adult briefs, toothpaste, etc. to last them the length of their stay.

Referral Form

Sleep Information				
Sleeps through the night:	☐ Yes ☐ No		Requires hospital bed:	☐ Yes ☐ No
Walk in their sleep:	☐ Yes ☐ No		In and out of bed frequently:	☐ Yes ☐ No
Have nightmares/terrors:	☐ Yes ☐ No		Typical wake time:	Time:
Night time enuresis:	☐ Yes ☐ No		Typical bed time:	Time:
Enuresis frequency:	X's per night		Does person nap during day	☐ Yes ☐ No

Tobacco usage	
Does the person smoke: ☐ Yes ☐ No	How many per day: Frequency:
Does the person use smokeless tobacco: ☐ Yes ☐ No	How much per day: Frequency:

*Consumers will need to bring enough tobacco products with them to last 30 days while at the CRU.

Ambulation		
Can walk independently:	☐ Yes ☐ No	Describe assistance needed:
Can walk up/down stairs:	☐ Yes ☐ No	Describe assistance needed:
Uses Wheelchair/Walker/Other to assist with ambulation:	☐ Yes ☐ No	What is used to assist with ambulation:
History of falls:	☐ Yes ☐ No	When was the last fall: What are known cause(s) for the falls: What is done to address the falls issue:
Assistance needed to exit in case of fire:	☐ Yes ☐ No	Describe assistance needed:

Referral Form

Is this person involved with any legal proceedings at this time? ☐ Yes ☐ No
If yes then please explain: ______________________________

____

Legal History		
Location	**Date**	**Reason**

Referral Form

Client Behavior Information

Behavior			Describe the frequency and duration
Property Destruction	☐ Yes	☐ No	
SIB Behavior	☐ Yes	☐ No	
Non-Compliance	☐ Yes	☐ No	
Verbal Aggression	☐ Yes	☐ No	
Physical Aggression	☐ Yes	☐ No	
Uses Weapons	☐ Yes	☐ No	
Biting	☐ Yes	☐ No	
Hair Pulling	☐ Yes	☐ No	
Spitting	☐ Yes	☐ No	
Head butting	☐ Yes	☐ No	
PICA	☐ Yes	☐ No	
Rumination	☐ Yes	☐ No	
Suicidal Ideations	☐ Yes	☐ No	
Elopement	☐ Yes	☐ No	
Sexually aggressive	☐ Yes	☐ No	
Sexually inappropriate	☐ Yes	☐ No	
Other:	☐ Yes	☐ No	

Explain how each of the identified behaviors above are being addressed at this time:

Continued on next page:

Referral Form

Client Behavior Information continued

continued:

Behavior Plan, Protocol, Guidelines	
Does this person have a Positive Behavior Support Plan in place? ☐ Yes ☐ No	
Behavior Protocol ☐	Behavior Guideline ☐
Behavior Not addressed at this time. ☐	Plan is currently being developed. ☐

Fast Triggers	Slow Triggers

Behavioral Pre-cursers

Identified Effective Reinforcers

Referral Form

Client Medical Provider Information

Service Provider	Providers Name	Phone Number	Fax Number
Primary Care Doctor			
Psychiatrist			
Neurologist			
Pharmacy			
Other:			
Other:			
Other:			
Other:			

Service Provider	Last Appointment	Were changes to medications made	Next Appointment
Primary Care Doctor		☐ Yes ☐ No	
Psychiatrist		☐ Yes ☐ No	
Neurologist		☐ Yes ☐ No	
Other:		☐ Yes ☐ No	
Other:		☐ Yes ☐ No	
Other:		☐ Yes ☐ No	
Other:		☐ Yes ☐ No	

If medications were recently changed, please complete the following:

Service Provider	Changes made

Durable medical equipment used (shower chair, C-pap machine, etc.)	

Referral Form

Vital Signs					
BP:	HR:	Resp:	Temp:	HT:	WT:

Allergies
Medication:
Food:
Environmental:

Current Medications			
Medication (Include PRN)	Frequency	Dosage	Purpose

***If coming from an agency – Send Medication Administration Record (MAR)**

Special Instructions for Mediation Administration (Take with food, crush meds, etc.)

Consumer must come with 30-day supply of medication and one refill of each medication

Referral Form

Medical History			
Problem	Yes	No	Comment
Special Diet			Type:
Pulmonary(Lung) Problems			Uses Oxygen: ☐ Yes ☐ No Describe:
Hypertension			Controlled: ☐ Yes ☐ No
Diabetes			Insulin Dependent? ☐ Yes ☐ No Frequency of Acue checks:
Heart Problems			Describe:
Seizure Disorder			Last Seizure? Type:
Stroke/Paralysis			Describe Limitations:
Cerebral Palsy			Limitations:
Recent Head Trauma			Describe:
Infectious Diseases			Describe: Treatment:
MERSA/VRE			Location: Date: Currently being treated:
Gastrointestinal Problem			Describe: How Long: BM Pattern:
Sensory Impairments			Describe: Glasses ☐ Hearing aids ☐
Cancer			Type: Currently In Tx: ☐ Yes ☐ No
Pregnant			LMP: OB Provider:
Rash			Where/How long/Source:
Physical limitations/amputations			Describe:

Hospitalization/Surgical History		
Hospital	**Date(s)**	**Reason**

Referral Form

Psychiatric information

Psychiatric Medications History (What has been tried/failed in the past)			
Medication	Dosage	Purpose	Date/Reason discontinued

Describe the clients change in behavior as compared to their typical behavior Be Specific in your description

Person(s) to speak with about client behavior if more information is needed		
Name	Phone #	Relationship

Referral Form

Recent Changes (Events or changes that have occurred in the past three months)
Environmental changes:
Changes in family dynamics:
Loss of a loved one or pet:
Anniversary of a traumatic event:
People present when problem behaviors occurred:
Topics that the person would talk about:
Other Changes:

Referral Form

Additional Information that may be useful

Referral Form

Additional Information to be sent along with referral packet

Form / Document	Attached	Comments
Physical/Medical Examination	☐ Yes ☐ No	
Psychological Evaluation	☐ Yes ☐ No	
Most recent Psychiatric Evaluation	☐ Yes ☐ No	
Social History	☐ Yes ☐ No	
Current Treatment / Support Plan	☐ Yes ☐ No	
Nursing Assessment	☐ Yes ☐ No	
Copy of Medicaid Card	☐ Yes ☐ No	
Copy of Medicare Card	☐ Yes ☐ No	
Other Insurance Card	☐ Yes ☐ No	
MAR	☐ Yes ☐ No	
Copy of Guardianship/Healthcare surrogate/Medical power of attorney	☐ Yes ☐ No	