

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: _____	KEPRO ID#: _____
County: _____	Social Security #: _____
Medicaid ID# _____	Annual IPP Date: _____
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Ethnicity: _____ Age: _____
Living situation: <input type="checkbox"/> Natural Family, <input type="checkbox"/> I/DD Waiver ISS, <input type="checkbox"/> ICF/IID, <input type="checkbox"/> Specialized Family Care Provider, <input type="checkbox"/> 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.

Representative Payee Yes, No

Agency/Name: _____	Phone #: _____
E-mail: _____	Fax#: _____

Medley Advocate Yes, No

Agency: _____	Phone#: _____
Name: _____	Other #: _____
E-mail: _____	Fax#: _____

Southern Highlands CMHC Crisis Response Unit

Referral Form

Service Coordinator/Case Manager

Agency: _____	Phone#: _____
Name: _____	Other #: _____
E-mail: _____	Fax#: _____

Service Coordinator Supervisor

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)

<input type="checkbox"/> Title XIX Waiver	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare
<input type="checkbox"/> Private Pay	<input type="checkbox"/> Other:	<input type="checkbox"/> 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

Client Daily Living Skills

Southern Highlands CMHC Crisis Response Unit

Referral Form

Toileting	
Can toilet independently	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requires some assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No
*Uses adult briefs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Menses Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Schedule needed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can sit on toilet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can indicate need	<input type="checkbox"/> Yes <input type="checkbox"/> No

Bathing	
Is able to stand in shower	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can bath them selves	<input type="checkbox"/> Yes <input type="checkbox"/> No
Needs assistance with bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can use a washcloth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can use Soap	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can use shampoo	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can use a towel	<input type="checkbox"/> Yes <input type="checkbox"/> No

Communication	
Verbal (Can make needs known)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Verbal (Has some difficulties)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Non-verbal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses sign language	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses gestures to communicate	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unable to make needs known	<input type="checkbox"/> Yes <input type="checkbox"/> No

Sexuality Information	
Sexually aggressive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Masturbates	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of inappropriate activity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Exposes self to others	<input type="checkbox"/> Yes <input type="checkbox"/> No
Attempts to see others naked	<input type="checkbox"/> Yes <input type="checkbox"/> No
Talks about sex frequently	<input type="checkbox"/> Yes <input type="checkbox"/> No

Eating	
Feeds self	<input type="checkbox"/> Yes <input type="checkbox"/> No
Needs to be fed by staff	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses utensils	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adaptive utensils used	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can drink independently from cup	<input type="checkbox"/> Yes <input type="checkbox"/> No

Eating cont.	
Does food need to be chopped	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does food need to be pureed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Attempts to eat to fast	<input type="checkbox"/> Yes <input type="checkbox"/> No
Needs liquids thickened	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swallowing issues	<input type="checkbox"/> Yes <input type="checkbox"/> No

Oral Hygiene	
Able to brush teeth independently	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has/uses dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Able to care for dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Able to use toothbrush	<input type="checkbox"/> Yes <input type="checkbox"/> No
Able to apply toothpaste	<input type="checkbox"/> Yes <input type="checkbox"/> No
Needs total oral care	<input type="checkbox"/> Yes <input type="checkbox"/> No

Dressing	
Needs assistance to dress self	<input type="checkbox"/> Yes <input type="checkbox"/> No
Independently put on pants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Independently put on shirt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Independently put on underwear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Independently put on socks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Independently put on bra	<input type="checkbox"/> Yes <input type="checkbox"/> No

If the Client uses adult briefs then indicate usage.

Wear them 24/7 <input type="checkbox"/>	During the day only <input type="checkbox"/>	Night time only <input type="checkbox"/>	Outings only <input type="checkbox"/>
---	--	--	---------------------------------------

*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.

Sleep Information

Sleeps through the night:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Requires hospital bed:	<input type="checkbox"/> Yes <input type="checkbox"/> No
---------------------------	--	------------------------	--

Southern Highlands CMHC Crisis Response Unit

Referral Form

Walk in their sleep:	<input type="checkbox"/> Yes <input type="checkbox"/> No	In and out of bed frequently:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have nightmares/terrors:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typical wake time:	Time:
Night time enuresis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typical bed time:	Time:
Enuresis frequency:	X's per night	Does person nap during day	<input type="checkbox"/> Yes <input type="checkbox"/> No

Tobacco usage	
Does the person smoke: <input type="checkbox"/> Yes <input type="checkbox"/> No	How many per day: Frequency:
Does the person use smokeless tobacco: <input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Describe assistance needed:</u>
Can walk up/down stairs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Describe assistance needed:</u>
Uses Wheelchair/Walker/Other to assist with ambulation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>What is used to assist with ambulation:</u>
History of falls:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>When was the last fall:</u>
		<u>What are known cause(s) for the falls:</u>
		<u>What is done to address the falls issue:</u>
Assistance needed to exit in case of fire:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Describe assistance needed:</u>

Is this person involved with any legal proceedings at this time? Yes No

If yes then please explain: _____

Referral Form

Legal History

Location	Date	Reason

Client Behavior Information

Referral Form

Behavior	Describe the frequency and duration
Property Destruction <input type="checkbox"/> Yes <input type="checkbox"/> No	
SIB Behavior <input type="checkbox"/> Yes <input type="checkbox"/> No	
Non-Compliance <input type="checkbox"/> Yes <input type="checkbox"/> No	
Verbal Aggression <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Aggression <input type="checkbox"/> Yes <input type="checkbox"/> No	
Uses Weapons <input type="checkbox"/> Yes <input type="checkbox"/> No	
Biting <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hair Pulling <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spitting <input type="checkbox"/> Yes <input type="checkbox"/> No	
Head butting <input type="checkbox"/> Yes <input type="checkbox"/> No	
PICA <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rumination <input type="checkbox"/> Yes <input type="checkbox"/> No	
Suicidal Ideations <input type="checkbox"/> Yes <input type="checkbox"/> No	
Elopement <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexually aggressive <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexually inappropriate <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other: <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

Continued on next page:

Client Behavior Information continued

Referral Form

continued:

Behavior Plan, Protocol, Guidelines	
Does this person have a Positive Behavior Support Plan in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Behavior Protocol <input type="checkbox"/>	Behavior Guideline <input type="checkbox"/>
Behavior Not addressed at this time. <input type="checkbox"/>	Plan is currently being developed. <input type="checkbox"/>

Fast Triggers	Slow Triggers

Behavioral Pre-cursors

Identified Effective Reinforcers

Client Medical Provider Information

Referral Form

Medical History

Problem	Yes	No	Comment
Special Diet			Type:
Pulmonary(Lung) Problems			Uses Oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
Hypertension			Controlled: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes			Insulin Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Hearing aids <input type="checkbox"/>
Cancer			Type: Currently In Tx: <input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant			LMP: OB Provider:
Rash			Where/How long/Source:
Physical limitations/amputations			Describe:

Hospitalization/Surgical History

Hospital	Date(s)	Reason

Psychiatric information

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:

Additional Information that may be useful

Referral Form

<u>Form / Document</u>	<u>Attached</u>	<u>Comments</u>
Physical/Medical Examination	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Psychological Evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Most recent Psychiatric Evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Social History	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Current Treatment / Support Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Behavior data/summary for past 3 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Nursing Assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Copy of Medicaid Card	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Copy of Medicare Card	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other Insurance Card	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
MAR	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Copy of Guardianship/Healthcare surrogate/Medical power of attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____