THE KLEIN FAMILY
HARFORD CRISIS CENTER

24/7 Mental Health and Addiction Services

RESIDENTIAL CRISIS SERVICES REFERRAL CHECKLIST

Date/Time of referral: _____

Facility Name: _____

Contact Person Name: _____

Contact Phone Number: _____

GUEST INFORMATION

1. Guest name: _____

2. Chief complaint / reason for admission request:

_____

_____

3. Guest age: _____

4. Diagnosis of Intellectual Disability, Substance Use, or Dementia? No Yes (circle one)

5. Psychiatric diagnosis: _____

6. Housing needs? No Yes (circle one)

If yes, explain: _____

_____

7. Current legal problems / court dates?

No Yes (circle one)

If yes, explain: _____

_____

8. Date of last inpatient psychiatric admission: _____

MEDICAL REVIEW

1. Vital signs:

T- P- R- BP- SP02- Pain-

2. On oxygen? No Yes (circle one)

3. Abnormal labs: _____

_____

4. Pregnant? No Yes (circle one) Weeks: _____

5. Medical Diagnosis: _____

6. In the guest toxicology screen positive?

No Yes (circle one)

List any positives: _____

7. Blood alcohol level if applicable: _____

8. Does the guest require assistance with ambulation or self-care? No Yes (circle one)

If yes, explain: _____

_____

10. Has the guest needed IM medications or restraints/ seclusion while in your facility?

No Yes (circle one)

If yes, explain: _____

_____

Please fax this form and current records to The Klein Family Harford Crisis Center. Fax 410-838-6108 / Phone 443-643-3439

University of Maryland Upper Chesapeake Health