



Crossroads LTSR

337 Tippecanoe Road – Smock Pa, 15480
Phone: 724-677-4445 Fax: 724-677-2379

LTSR CRITERIA CHECKLIST

(PLEASE PRINT LEGIBLY)

Consumer's Name: _____ **Date:** _____

Person Completing Referral: _____ **Agency:** _____

Phone: _____ **Ext:** _____ **Email:** _____

18 years or older

Psychiatric Diagnosis
Psychiatric Evaluation Attached Yes No, explain _____

Medically Stable (vital signs stable, lab findings within normal limits, no complications due to coexisting medical problems, does not require intensive medical interventions/monitoring)

Out of Seclusion or restraint for a minimum of 30 days
 Yes No, explain _____

Ability to provide self-care **Ability to ambulate stairs**

Physical examination within 6 months
Physical Evaluation Attached Yes No, explain _____

Current PPD (TB Test) - Results Attached Yes No, explain _____

Current MRSA Status - Results Attached Yes No, explain _____

Current Commitment Status 201 304 305 306
Commitment Attached Yes No, explain _____

Physician Certification
Certification Attached Yes No Certification that individual does not require hospitalization or a level of care more restrictive than LTSR. (Will not admit without signature)

Social History
Social History Attached Yes No, explain _____

Admit Note and 10 Days Most Recent Progress Notes
Progress Notes Attached Yes No, explain _____

Does Individual Have Advance Directive Yes No
If yes, Advance Directive Attached Yes No, explain _____

2 Weeks of Medication Supply Due to complex insurance issues we request 2 weeks of medication to accompany the individual upon admission to LTSR.

Medication List
Medication Attached Yes No, explain _____

Demographic Information

Consumer's Name: _____ **Gender:** Male Female

Social Security Number: _____ **Date of Birth:** _____ **Age:** _____

Address _____
State _____ **ZIP** _____ **Phone** _____

Education: Grade School HS Diploma/GED Trade School College Masters Other: _____

Employment: FT PT Student Other: _____ **Location:** _____

Marital Status: Single Never Married Married Divorced Separated Widowed Significant other:
Spouse/Significant Other Name: _____ **Phone:** _____

Living Information: Own Apartment/House Spouse/Significant Other Personal Care Home Parents
 Homeless Supervised Living

Children: Yes No **Number under 18yrs:** _____ **Number over 18yrs:** _____ **Custody** Yes No
If no, does client have access/visitation? Yes No

Emergency Contact: _____ **Contact Phone:** _____

Relationship to Emergency Contact: _____

Financial and Insurance Information

SSI/SSDI: Yes No Application Made; date: _____ **Monthly Amt \$** _____

Public Assistance: Yes No Application made; date: _____ **Monthly Amt \$** _____

Other Income: _____ **Monthly Amt \$** _____

Representative Payee: Yes No Application made; date: _____
Payee Name: _____ **Payee Phone:** _____

Medicare Benefits: Yes No Application made; date: _____

Medicaid Benefits: Yes No Application made; date: _____

Veterans Admin Benefits: Yes Application made; date: _____

Primary Insurance Provider _____ **ID #** _____ **Policy #** _____

Secondary Insurance Provider _____ **ID #** _____ **Policy #** _____

Other Insurance Provider _____ **ID #** _____ **Policy #** _____

Psychiatric Information

Current Admission Date: _____ Court Order on Admit: 201 302 304/305

Previous Admit Date: _____ Duration Previous Admit: _____ days/months

Number of Hospitalizations Past Year: _____

Number of Hospitalizations Life Time: _____

Restraint used this admission Yes No Dates: _____

Seclusion used this admission Yes No Dates: _____

Reason for this Admission to Facility: _____

Summary of Issues, Behavior, and Treatment Interventions while at your facility:

Psychiatric Diagnosis

Axis I: _____

Secondary: _____

Axis II: _____

Secondary: _____

Axis III: _____

Secondary: _____

Axis IV: _____

Secondary: _____

Axis V: Admit: _____ Current: _____

Primary Psychiatrist: _____ Agency: _____ Phone: _____

Case Management (ICM): Yes No Referral Made; date; _____

ICM Agency _____ Case Manager Name: _____

Substance Abuse Information

Substance Abuse prior to this hospitalization: None Cocaine Crack Alcohol Marijuana PCP
IV Drug Heroin/Opiates Amphetamines Benzodiazepines Other: _____ Other: _____

Frequency: Not in last month 1-3x in last month 1-2x per week 3-6x per week Daily Unknown

History of substance abuse: None Cocaine Crack Alcohol Marijuana PCP IV Drug
Heroin/Opiates Amphetamines Benzodiazepines Other: _____ Other: _____

Frequency: Not in last month 1-3x in last month 1-2x per week 3-6x per week Daily Unknown

Drug screen completed at admission: Yes No **Results:** _____

| | | |
|-------------------------------------|-----------------|-----------------|
| Drug/Alcohol Rehab Facility: | Date(s): | Outcome: |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Current Medical Information

Current Medication List Attached Yes No

Primary Physician: _____ **Specialty:** _____ **Phone:** _____

Other Physician: _____ **Specialty:** _____ **Phone:** _____

Other Physician: _____ **Specialty:** _____ **Phone:** _____

Check All That Apply

| | | |
|---|--|--|
| <input type="checkbox"/> AIDS <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Amputation <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Diathesis <input type="checkbox"/> Blindness <input type="checkbox"/> Bone Disease <input type="checkbox"/> Cancer <input type="checkbox"/> CHF (congestive heart failure) <input type="checkbox"/> Colostomy <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> COPD <input type="checkbox"/> CVA (stroke) <input type="checkbox"/> Cystostomy <input type="checkbox"/> Deafness | <input type="checkbox"/> Dementia <input type="checkbox"/> Dermatitis Condition <input type="checkbox"/> Diabetes <input type="checkbox"/> <small>insulin-dependent</small> <input type="checkbox"/> Dialysis <input type="checkbox"/> GI Condition <input type="checkbox"/> GU Condition <input type="checkbox"/> Hepatic Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV+ <input type="checkbox"/> Head trauma (TBI) <input type="checkbox"/> Hypertension <input type="checkbox"/> Incontinence <input type="checkbox"/> <small>Nighttime</small> <input type="checkbox"/> <small>Daytime</small> <input type="checkbox"/> <small>Regularly</small> <input type="checkbox"/> <small>Intermittent</small> <input type="checkbox"/> Metabolic Dysfunction <input type="checkbox"/> Paraplegia | <input type="checkbox"/> Paralysis <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Renal disease <input type="checkbox"/> Rheum Disorder <input type="checkbox"/> Seizure History <input type="checkbox"/> Thyroid Disorder <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ ALLERGIES <input type="checkbox"/> Allergy: _____ <input type="checkbox"/> Allergy: _____ <input type="checkbox"/> Allergy: _____ <input type="checkbox"/> Allergy: _____ |
|---|--|--|

Comments: _____

TB Clearance: **PPD Completed:** YES NO **Evidence of Active TB:** YES NO
PPD results: _____ **Date Planted:** _____ **Date Read:** _____
If positive, was X-ray done? Yes No **X-ray Result:** _____

Current Height _____ **Weight** _____ **Blood Pressure** _____ **Temperature** _____

Individual Smoke: Yes No **Packs per Day** _____ **How often** _____

Tobacco Use: Yes No **How often** _____

Current Legal Status

Legal Status: None Probation Parole Incarceration Warrants Fines Pending Charges

Probation/Parole Contact: _____ **Phone:** _____

Attorney's Name: _____ **Phone:** _____

Reason for Arrest: _____

Legal HX: _____

Physician Certification Statement

Statement of Physician Certification

I, _____ am certifying that, the least restrictive and most appropriate placement for _____ is within a Long-Term Structured Residential Facility (LTSR). I do hereby certify that the consumer is not in need of acute psychiatric hospitalization, nursing facility care, or a level of care more restrictive than a Long-Term Structured Residential Facility at this time.

Physician's Signature

Date