CROSSROADS LTSR REFERRAL

1100 S PITTSBURGH ST CONNELLSVILLE PA 15425
PHONE: 724-626-9603 FAX: 724-626-9607

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

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

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

LTSR CRITERIA CHECKLIST

☐**18 Years or older**

☐**Psychiatric Diagnosis**

Psychiatric Evaluation attached: ☐Yes ☐No – If no, explain_____

☐**Medically stable** (Vital signs stable, lab findings do not present acute risk, no complications due to coexisting medical problems, does not require intensive medical interventions or monitoring.)

☐**Out of Seclusion or restraint for a minimum of 30 days**

☐**Ability to provide self-care**

☐**Ability to ambulate stairs**

☐**Physical examination within 6 months**

Physical Evaluation attached: ☐Yes ☐No – If no, explain_____

☐**Current PPD (TB Test)**

PPD results attached: ☐Yes ☐No – If no, explain_____

☐**Current Commitment Status** ☐**201** ☐**304** ☐**305** ☐**306**

Commitment attached: ☐Yes ☐No – If no, explain_____

☐**Physician Certification** (Certification that the individual does not require hospitalization or level of care more restrictive than LTSR. Will not admit without signature.)

Certification attached: ☐Yes ☐No

☐**Social History**

Social History attached: ☐Yes ☐No – If no, explain_____

☐**Admit Note and 10 Days Most Recent Progress Notes**

Progress Notes attached: ☐Yes ☐No – If no, explain_____

☐**Does Individual Have Advanced Directive**

If yes, Advanced attached: ☐Yes ☐No **–** If no, explain_____

☐**2 Weeks of Medication Supply**

Due to complex insurances issues we request 2 weeks of medication to accompany the individual upon admission to LTSR

☐**Medication List**

Medication attached: ☐Yes ☐No **–** If no, explain_____

DEMOGRAPHIC INFORMATION

Consumer Name: _____ **Gender:** ☐Male ☐Female

SS#: _____ **DOB:** _____ **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 Info:	☐Own House or Apartment	☐Spouse or Significant Other	☐Personal Care Home	☐Homeless	☐Supervised Living	
Children:	☐Yes	☐No	Number under 18 yrs:____	Number over 18 yrs:____	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 ☐Applied	**Date:** _____	**Monthly Amount** $_____
Public Assistance: ☐Yes ☐No ☐Applied	**Date:** _____	**Monthly Amount** $_____
Other Income: _____		**Monthly Amount** $_____

Representative Payee: ☐Yes ☐No ☐Applied Date: _____

Payee Name:_____ Payee Phone:_____

Medicare Benefits: ☐Yes ☐ No ☐Application Made; date:_____
Medicaid Benefits: ☐Yes ☐ No ☐Application Made; date:_____
Veterans Admin Benefits: ☐Yes ☐ No ☐Application Made; date:_____

Primary Insurance Provider: _____	**ID#:**_____
Secondary Insurance Provider: _____	**ID#:**_____
Other Insurance Provider: _____	**ID#:**_____

PSYCHIATRIC INFORMTION

Current Admission Date:_____ **Court Order on Admit:** ☐201 ☐302 ☐ 304/305
Previous Admit Date: _____ **Duration Previous Admit:** _____

Restraint used this admission: ☐Yes ☐No Dates: _____
Seclusion used this admission: ☐Yes ☐No Dates: _____

Reason for Admission to Facility:

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

PSYCHIATRIC DIAGNOSIS

Problem1:

Problem 2:

Problem 3:

Problem 4:

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	☐Alcohol	☐Marijuana	☐PCP
☐IV Drug	☐Heroin/Opiates	☐Amphetamines	☐ Benzodiazepines	☐Other _____

Frequency:

☐Not in the last month	☐1-3x last month	☐1-2x per week	☐3-6x per week	☐Daily	☐Unknown

History of Substance Abuse:

☐None	☐Cocaine	☐Alcohol	☐Marijuana	☐PCP
☐IV Drug	☐Heroin/Opiates	☐Amphetamines	☐ Benzodiazepines	☐Other _____

Frequency:

☐Not in the last month	☐1-3x last month	☐1-2x per week	☐3-6x per week	☐Daily	☐Unknown

Drug screen completed at admission: ☐Yes ☐No

Results:

Drug/Alcohol Rehab Facility:	**Dates:**	**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

☐AIDS	☐Amputation	☐Anemia	☐Angina	☐Asthma
☐Bleeding Diathesis	☐Blindness	☐Bone Disease	☐Cancer	☐Colostomy
☐Congestive Heart Failure	☐COPD	☐Coronary Artery Disease	☐CVA	☐Cystostomy
☐Deafness	☐Dementia	☐Dermatitis	☐Diabetes	☐Dialysis
☐GI Condition	☐GU Condition	☐Head Trauma (TBI)	☐Hepatic Disease	☐Hepatitis
☐Hypertension	☐Incontinence	☐Metabolic Dysfunction	☐Pancreatitis	☐Paralysis
☐Paraplegia	☐Renal Disease	☐Rheum Disorder	☐Seizure Control	☐Thyroid Disorder
☐Tracheotomy	☐Other_____	☐Other_____	☐Other_____	☐Other_____

Allergies:

Comments:

TB CLEARANCE

PPD Completed	☐Yes ☐No	**Evidence of Active T**	☐Yes ☐No
PPD Results: _____		**Date Planted:** _____	**Date Read:** _____
If positive, X-ray done?	☐Yes ☐No	**X-ray result:** _____	

Height:_____ **Weight:**_____ **Blood Pressure:**_____ **Temperature:**_____

Tobacco Use: ☐Yes ☐No What type: _____ How Often:_____

CURRENT LEGAL STATUS

Legal Status: ☐None ☐Probation ☐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 the 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.

Referring Professional (MD, DO, CRNP, PA-C)
Name: _____ **NPI:** _____
Medicaid Provider #:_____

X_____ _____
Physician's Signature **Date**