

# INPATIENT REFERRAL / ASSESSMENT FORM

**BROOKWOOD** (Birmingham, AL) | Adult & Geriatric Unit  
**CITIZENS** (Talladega, AL) | Geriatric Unit  
**SHELBY** (Alabaster, AL) | Adult & Geriatric Unit  
**PRINCETON** (Birmingham, AL) | Geriatric Unit  
**WALKER** (Jasper, AL) | Adult & Geriatric Unit

**Phone: 1-84-GOBBHNOW**  
**Fax: (844) 727-0795**



**Psychiatry**

Reviewed by: _____ Date _____ Time _____	
Call time _____ Call Date: _____ Signature person taking call _____	
Caller _____ Phone _____ Alternate Phone _____	
Family _____ Relationship _____ Is this DPOA/Guardian/Conservator: Yes ___ No ___ Does patient have one? ___ Yes ___ No ___ Unknown	
Facility _____ Name _____ FAX _____ Permission to call back: Yes ___ No ___	
<b>Clinical information:</b>	
<b>Patient Information:</b>	
Presenting problem: _____	Name: _____
_____	Address: _____
_____	Age _____ DOB: ____/____/____ Male ___ Female ___
_____	Social _____ Married ___ Widow ___ Single ___ Divorced
_____	Additional Contact: _____
_____	Phone: _____ DPOA/Guardian/Conservator Yes ___ No ___
Medical conditions: _____	Primary Care: _____
_____	Contacted: ___ Yes ___ No Last seen: _____
Vision _____	Psychiatrist: _____
Hearing: _____	Contacted: ___ Yes ___ No Last seen: _____
ADLs: Independent Assisted Hx Falls Continent Total care	<b>Insurance:</b> Permission to verify benefits Yes _____ No _____
Ambulatory With assist Walker Cane Diet _____	Medicare # _____
Medications: (Include OTC and not to be used as admitting med list) _____	Medicaid # _____
_____	Other: _____ # _____ Grp# _____
_____	Other: _____ # _____ Grp# _____
<b>Admission Criteria:</b>	
<b>Disposition:</b>	
Y N Suicide ideation Attempt Plan Self Mutilating	Assessment scheduled
Date: _____ Describe: _____	Refused assessment/admission
Y N Assaultive/destructive/homicidal w/ poor impulse control	Medical Clearance
Y N Disorientation/Mental impairment poses risk	Medical condition primary
Y N Psychiatric symptoms causing bizarre/disordered behavior (describe)	Pre Certification denied
Y N Sleep/Nutritional disturbance poses risk	Not HMO/PPO
Y N Acute exacerbation of chronic symptoms	Age inappropriate
Y N Psych med withdrawal/change/adjust/toxic/noncompliance	Pre Certification denied
Y N Failed less intensive level of care	Admission criteria not met: (Describe)
Y N History psychiatric Tx ___outpatient ___ Inpatient	Admitted ___ Voluntary ___ Involuntary
Y N Other _____	MD contacted for admission disposition:
	_____ Time _____ Date _____
	Disposition/provisional diagnosis per MD:
	_____ Time _____ Date _____
	Clinician signature _____ Time _____ Date _____