Buena Vista
REGIONAL MEDICAL CENTER

Referring Facility: _____

Contact Person: _____

Phone: _____

Fax: _____

Hope Harbor Admission Process:

IN ORDER TO EXPEDITE THE ADMISSION PROCESS, ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED AND FAXED TO HOPE HARBOR (ALONG WITH THIS SIGNED LIST). PLEASE WAIT UNTIL ALL INFORMATION IS COLLECTED PRIOR TO FAXING (712-213-4034).

1. *Copy of **complete** History and Physical **within the past 6 months.***
2. *Recent lab work, CBC, BMP and UA-within 2 weeks prior to admission. **The H&P and lab work will be reviewed by our medical director to determine if patient is medical stable and meets criteria for admit.***
3. *Complete form list of attempted medical and non-medical interventions used, dates and outcomes for the past few days. **This is essential. Please do NOT send pages of nursing progress notes.***
4. *List of current medications/MAR*
5. *Demographic information/Face Sheet*
6. *Signed consent to return to the facility. **This must be signed by a DON and/or Administrator of the facility.***
7. *Copy of front and back of updated Medicare and other insurance cards.*
8. *Copy of Advanced Directives-Medical Power of Attorney, Living Will, etc.*
9. *Copy of Code Status.*
10. *Copy of court committal papers, if applicable.*
11. *Copy of Social History, if available.*
12. *Copy of psychiatrist notes/evaluation, if applicable.*
13. *Patient medical doctor approval (**does not have to be in writing**).*
14. *Family approval (**does not have to be in writing but family MUST approve admit**)*
15. *Copy of resident falls report with dates and injuries.*

Pt Flu Vac Date:_____ Pt Pneumo Vac Date:_____

Does pt have history of MRSA and/or VRE? _____yes _____no. If yes, provide documentation.

Signature of person completing this form: _____

General information:

Items to bring to Hope Harbor: Comfortable clothing for 3 days. Comfortable soft shoe, walker, wheelchair or any assistive devices (please mark with facility name), hearing aids and hearing aid batteries, dentures and glasses. Items NOT to bring: Money, metal hangers, belts, purses/wallets with valuables, valuable jewelry, any glass items or cell phones.

Melissa, BVRMC social worker, will call you as soon as information is reviewed and let you know if additional information is needed and when a bed is available. For questions, please call Melissa at 712-213-8615. Thank you for your referral!

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Hope Harbor Behavioral Health Unit

Phone: 712-213-8656

Fax: 712-213-4034

We have requested inpatient treatment for _____ at Buena Vista Regional Medical Center-Hope Harbor Behavioral Health Unit. We agree to have this patient/resident return to our facility when Hope Harbor determines that criteria for discharge has been met.

** We also understand it is the responsibility of our facility to arrange for transportation to and from Hope Harbor.

_____	_____
Facility	Date
_____	_____
Signature of Administrator or DON	Title

Buena Vista
REGIONAL MEDICAL CENTER

This form must be completed and returned to Hope Harbor

Patient Name: _____ **Age:**_____ **Facility:** _____

Date of initial referral call: _____

1. **Behaviors & date of each behavior:** Please describe in detail (rather than documenting “aggressive” indicate what the act of aggression was Ex. “Res pulled RN hair”).

2. **Non-medical Interventions Used and Outcome:** What non-medical interventions have been tried and how did the patient/resident respond to these interventions?

3. **Medical Interventions Used and Outcome:** The date the medication was prescribed, by whom and how often. Was the medication beneficial or not?

Completed by: _____ Date/Time: _____

PLEASE FILL OUT THE FOLLOWING INFORMATION FOR HOPE HARBOR REFERRAL

And return with other referral information

ADMITTING INFO:

Admitting Physician- Transportation provided by:

History of Covid-19: ☐ No ☐ Yes, Date: Admission Covid-19 Test Results: ☐ Negative

REFFERAL SOURCE INFORMATION

Caller Name: Organization: Telephone:

Facility Address Fax:

Level of Care: Skilled / ICF / Assisted Living / Memory Care

PATIENT INFORMATION

Patient Name: DOB: Age: ☐M ☐ F Marital Status:

Address: Telephone:

Ethnicity: Primary Language: Spirituality:

Legal Status: ☐ Voluntary ☐ Involuntary Guardianship/Conservator: ☐ Yes ☐ No **POA: ☐ Yes ☐ No**

☐ DNR ☐ FULL CODE Forms sent? ☐ Yes ☐ No

CARETAKER / PHYSICIAN INFORMATION

Responsible Party: Relationship: Telephone:

Address: Cell:

Primary Physician: Telephone: MD aware of referral? ☐ Y ☐ N

Address:

Pharmacy:

PRESENTING PROBLEM Briefly describe unusual behaviors reported by patient, family, physician, or referral source:

PREVIOUS PSYCHIATRIC TREATMENT / Long history of psych issues???? Yes / No

Previous Psychiatric Treatment: ☐ Site outpatient ☐ Primary care practitioner ☐ Other:

Dates and Nature of this treatment Dates: Type:

Medication: See Chart

Results: ☒ Pt failed outpatient tx and med adjustment and requires higher level of care in a safe secure environment.

MRI / CT Scan??? When and where?

INSURANCE INFORMATION

Medicare:☐Y ☐N Policy #

Medicaid:☐Y ☐N Policy #

Social Security # (if different from Medicare #)

Other Insurance/HMO: Policy #

MEDICAL INFORMATION

Dx

Recent Hospitalizations / Procedures:

Allergies: ☐ NKA (list)

History of: **MRSA:** ☐ Yes ☐ No **VRE:** ☐ Yes ☐ No
Pneumovac ☐ Yes ☐ No If Yes, Date: _____ TYPE_____
Flu Vac ☐ Yes ☐ No If Yes, Date: _____

Covid Vaccine: ☐ No ☐ Yes, Dates: / TYPE _____
Date: Smoker: ☐ Current ☐ Former ☐ Never
Skin Issues: _____
History of Allegations of Abuse:

SOCIALCULTURAL INFORMATION

Current living arrangements: Home / Nursing Home / Assisted Living _____
Date entered assisted living/nursing home: _____
Plans for living arrangements upon discharge: _____
Describe cultural issues or restrictions: _____
Any family history of mental illness, substance abuse, or symptoms similar to patients? _____

CURRENT LEVEL OF FUNCTIONING

Affective
- ☐ Depressed Mood
- ☐ Crying Spells
- ☐ ↓ Interest
- ☐ ▲ Sleep
- ☐ ▲ Appetite
- ☐ ↓Concentration
- ☐ ↓Activity level / fatigue
- ☐ Guilt
- ☐ ↑Activity level / energy
- ☐ Somatic Complaints
- ☐ Mania
- ☐ Suicidal ideation
- ☐ Anger
- ☐ Anxiety / fear
- ☐ Panic attacks

Cognition
- ☐ Disorientation
- ☐ Memory loss
- ☐ Impaired judgment
- ☐ Aphasia
- ☐ Apraxia
- ☐ Agnosia
- ☐ Disorganization
- ☐ Delusions
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Suspiciousness
- ☐ Obsessions

Behavioral
- ☐ Combative
- ☐ Agitation
- ☐ Wandering
- ☐ Bizarre
- ☐ Withdrawn
- ☐ Isolative
- ☐ Compulsive
- ☐ Suicidal

Substance Abuse
- ☐ Alcohol
- ☐ Rx Drugs
- ☐ Non-Rx Drugs

Current Stressors
- ☐ Deaths
- ☐ Illness
- ☐ ▲ living arrangement: _____
- ☐ Marital / family conflict:
- ☐ Physical, sexual, emotional abuse: _____
- ☐ Financial:
- ☐ Loss/limited transportation:
- ☐ Other: _____

Onset and duration of problems: _____

ADL ASSESSMENT

√Assist Level:	Independent	Minimal Assist	Moderate Assist	Maximum Assist
Eating				
Bathing				
Dressing				
Hygiene				

Current Mobility _____ Assistive Device: _____ Assist of & Distance: _____

Diet: _____ Appetite: _____ Difficulty swallowing: _____
Refuses to Eat: ☐ Yes ☐ No ☐ Sometimes Refuses to Drink: ☐ Yes ☐ No ☐ Sometimes
☐ Continent ☐ Incontinent of bladder ☐ Incontinent of bowel ☐ Occasionally incontinent ☐ Wears pads/briefs
Fall History: ☐ Past ☐ Present Most recent fall and injury? .
Medication Compliance: _____ Takes: ☐ Whole ☐ Crushed in: _____
Dentures: _____ Hearing Aide: _____ Glasses: _____
Wt Loss of 10 1bs. or more: _____
Additional information??

ADMISSION CRITERIA CHECKLIST
FOR INPATIENT TREATMENT

____ 1. Recent (within 72 hours) attempted suicide.
____ 2. Documentation of suicide ideation requiring suicide precautions.
____ 3. Assaultive behavior as a result of a psychiatric disorder
____ 4. Documentation of self-mutilative behavior as a result of a psychiatric disorder.
____ 5. Major depression (must have five or more of the following symptoms in the same 2 week period and at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure)

____ a. Depressed mood most of the day, nearly every day
____ b. Markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day
____ c. Significant weight loss when not dieting or weight gain, or decrease/increase in appetite nearly every day
____ d. Insomnia or hypersomnia nearly every day
____ e. Psychomotor agitation or retardation nearly every day
____ f. Fatigue or loss of energy nearly every day
____ g. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day
____ h. Diminished ability to think or concentrate, or indecisiveness, nearly every day
____ i. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

____ 6. Acute onset or acute exacerbation of hallucinations, delusions, illusions, the magnitude and severity of which threatens the patient's well-being.
____ 7. Inability of the patient to comply with prescribed psychiatric health regimens (i.e., taking prescribed psychotropic Medications, going to outpatient appointments to receive prescriptions and/or IM medications, etc.) in a patient who has a chronic history of decompensation without psychotropic medications, with documentation of reasonable expectation of improved compliance with inpatient hospitalization within a short period of time (less than or equal to 14 days).
____ 8. Potential hazard to the health or life of a patient who, due to concurrent psychiatric illness, is unable to comply With prescribed medical health regimens (e.g, insulin dependent diabetes, etc.).
____ 9. Acute onset of inability to cope with stressful situation.
____ 10. Acute onset of inability to care for self or attend to activities of daily living. AND documentation of reasonable expectation that resumption of self-responsibility will occur following appropriate treatment.
____ 11. Manic state admitted for injectable neuroleptics or rapid modification of psychotropic drugs or initiation of Lithium treatment.
____ 12. Evidence of symptoms and/or behavior or verbalization reflecting significant risk or potential danger (or actual Demonstrated danger) to self, others or property. **(Must be documented a minimum of every seven days.)**
____ 13. Other _____

Screen completed by Qualified Mental Health Professional

Signature: _____ Title: _____ Date: _____ Time: _____