|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Level of Care Requested (Select one. A separate referral form is need for each level of care.)  MHRC/STP  SD County Funded SNF  SNF Patch  NBU Patch  State Hospital  ARF  Community Care Bungalows \*Must have a well-documented Developmental Delay or Intellectual Disability and be declined  by all IMD/STP programs.  Request for Reconsideration \*Fax directly to the facilities, not to Optum. Summarize what improvements have been made  since the original referral. | | | | | | | | | | | | | | | |
| **Facility Information** | | | | | | | | | | | | | | | |
| Referring Facility:  Click or tap here to enter text. | | | | | | | | | | | | Admit Date:  Click or tap here to enter text. | | | |
| Contact Name:  Click or tap here to enter text. | | | | | | Phone:  Click or tap here to enter text. | | | | | | Fax:  Click or tap here to enter text. | | | |
| **Client Information** | | | | | | | | | | | | | | | |
| Client’s Name:  Click or tap here to enter text. | | | | | | | | Date of Birth:  Click or tap here to enter text. | | | | | | Age:  Click or tap here to enter text. | |
| Gender:  M  F  O | | Race:  Click or tap here to enter text. | | Marital Status:  Click or tap here to enter text. | | | | | 1st Language:  Click or tap here to enter text. | | | | 2nd Language:  Click or tap here to enter text. | | |
| Special Needs:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| SSI  Medicare #  SSA  Medi-Cal #  SSDI  Regional Center  Other  VA Benefit | | | | | TB Screen Date:  Click or tap here to enter text. | | | | | | | | | | |
| TB Results:  Click or tap here to enter text. | | | | | | | | | | |
| Allergies:  Click or tap here to enter text. | | | | | | | | | | |
| UDS at Admission | Results:  Click or tap here to enter text. | | | | BAL at Admission | | | | | Results:  Click or tap here to enter text. | | | | | |
| **Conservatorship Information** | | | | | | | | | | | | | | | |
| Conservatorship (\*\*Required\*\*)  Temporary  Permanent  Public  Private | | | | | | | | | | Date Established:  Click or tap here to enter text. | | | | | |
| Conservator/Court Investigator:  Click or tap here to enter text. | | | | | | | Telephone #:  Click or tap here to enter text. | | | | | | | | |
| Comments on Court Investigation:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Case Manager:  Click or tap here to enter text. | | | | | | | Telephone #:  Click or tap here to enter text. | | | | | | | | |
| Payee:  Click or tap here to enter text. | | | | | | | Telephone #:  Click or tap here to enter text. | | | | | | | | |
| If NO Payee, has an application been made for Payee Services? Click or tap here to enter text. | | | | | | | Date of Application:  Click or tap here to enter text. | | | | | | | | |
| **Diagnosis Information** | | | | | | | | | | | | | | | |
| Use DSM/ICD diagnosis and other clinical or medical considerations  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Primary Diagnosis:  Click or tap here to enter text. | | | | | | | ICD Code:  Click or tap here to enter text. | | | | | | | | |
| TBI/NCI, DD, Intellectual Disability Diagnosis:  Click or tap here to enter text. | | | | | | | Other Diagnosis (Clinical or Medical):  Click or tap here to enter text. | | | | | | | | |
| **Risk Factors** | | | | | | | | | | | | | | | |
| Current Risk Factors:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Historical Risk Factors:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Current Dangerous Propensities:  Click or tap here to enter text. | | | | | | | Historical Dangerous Propensities:  Click or tap here to enter text. | | | | | | | | |
| **Current Risk Factors** | | | **Weak Strong** | | | | | | | | | | | | |
| Weak to Strong | | | 1 | | | | 2 | | | | 3 | 4 | | | 5 |
| Suicidal Risk | | |  | | | |  | | | |  |  | | |  |
| AWOL Risk | | |  | | | |  | | | |  |  | | |  |
| Assaultive Risk | | |  | | | |  | | | |  |  | | |  |
| Drug/ETOH Risk | | |  | | | |  | | | |  |  | | |  |
| Sexual History Risk | | |  | | | |  | | | |  |  | | |  |
| Infectious Disease(s):  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| **Referral Information** | | | | | | | | | | | | | | | |
| Reason for Referral to This Level of Care (Why does the client need this level of care?):  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Current Treatment (Response to treatment, medication compliance, participation in groups, etc.):  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| History of Prior Hospitalizations/IMD/State Hospital/SNF Treatments (Include dates):  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Living Situation for Past 12 Months:  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Legal issues (Note any probation, warrants, or interaction with legal system):  Click or tap here to enter text. | | | | | | | | | | | | | | | |
| **Psychiatrist Information** | | | | | | | | | | | | | | | |
| Treating Psychiatrist Signature: | | | | | | | | | | | | | | | |
| Printed Name of Psychiatrist:  Click or tap here to enter text. | | | | | | | Phone:  Click or tap here to enter text. | | | | | | | | |

\*\*\*Please refer to the “Tips for Completing the LTC Referral Screening Form” which can be found on the Optum San Diego Website (https://optumsandiego.com) for more information.