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| **Member Demographics** | | | | | | | | | | | |  | | | | | |
| Last Name  Click here to enter text. | First Name  Click here to enter text. | | | | | | MI  \_\_\_ | | | | | Beneficiary ID: Click here to enter text. | | | | | |
| Admission Date: Click here to enter a date. | | | | | |
| Completed by: Click here to enter text. | | | | | | | | | | | | Admission TIME: \_\_\_ AM PM | | | | | |
| Date of birth: Click here to enter a date. | | | | | Age: \_\_\_ Gender: \_\_\_ | | | | | | | Telephone #: Click here to enter text. | | | | | |
| Address/Street  Click here to enter text. | | Apt. #  \_\_\_ | | | | City  Click here to enter text. | | | | | County  Click here to enter text. | | | State  KS | | Zip  Click here to enter text. | |
| Other Health Insurance? Yes  No If yes specify:  CMHC Responsibility: Choose an item.  Member Status: Choose an item. | | | | | | | | | | | | | | | | | |
| **Admission Type: Acute PRTF State Hosp Alt**  **Wheatland**  **Prairie Ridge** **State Hospital** | | | | | | | | | | | | | | | | | |
| Facility Name: Click here to enter text. | | | | | | | | | | | | | | | | | |
| Address/Street  Click here to enter text. | | | | City Click here to enter text. | | | | | | | State  KS | | | | Zip  Click here to enter text. | | |
| Facility ID: Click here to enter text. | | | | | | | | Facility NPI #: Click here to enter text. | | | | | | | | | |
| Facility telephone #: Click here to enter text. | | | | | | | | Fax #: Click here to enter text. | | | | | | | | | |
| Attending Physician name:  Click here to enter text. | | | | | | | | Telephone #:  Click here to enter text. | | | | | | | | | |
| Facility UM Reviewer:  Click here to enter text. | | | | | | | | Telephone #:  Click here to enter text. | | | | | | | | | |
| **Admission Assessment**  **Voluntary  Involuntary** | | | | | | | | | | | | | | | | | |
| Circumstances of admission: (Outpatient referral, ER, MFT, transfer from ICU, Medical, self-referral, other)  Click here to enter text. | | | | | | | | | | | | | | | | | |
| Specify current symptoms and behaviors that require hospitalization:  Click here to enter text. | | | | | | | | | | | | | | | | | |
| Results of lethality assessment: (describe current plan and level of intent)  Suicide Ideation Active SI Passive SI  Homicidal Ideation Active HI Passive HI  Means to carry out plan: Click here to enter text.  Member’s current frame of mind: (feeling justified in attempt, disappointment in failed attempt, etc.)  Click here to enter text. | | | | | | | | | | | | | | | | | |
| **Current Legal Status** | | | | | | | | | | | | | | | | | |
| Currently on Supervision: Yes  No If yes specify:  Custody: Choose an item.  Name of Contractor: Click here to enter text.  Dates of Custody: From: Click here to enter a date. To: Click here to enter a date. | | | | | | | | | | | | | | | | | |
| **Current** | | | | | | | | | | | | | | | | | |
| Current Mental status exam: (Current symptoms of distress or dysfunction, appearance, behavior, orientation, thought process/content, affect mood, memory, psycho motor status, judgment, impulse control, etc.)  Click here to enter text. | | | | | | | | | | | | | | | | | |
| Current Services: Click here to enter text. | | | | | | | | | | | | | | | | | |
| Current living arrangement, support system, psycho social stressors, history of abuse/trauma:  Click here to enter text. | | | | | | | | | | | | | | | | | |
| **Historical** | | | | | | | | | | | | | | | | | |
| Previous SI/HI attempts: Click here to enter text. | | | | | | | | | | | | | | | | | |
| History of prior inpatient psychiatric hospitalizations: Click here to enter text. | | | | | | | | | | | | | | | | | |
| **Substance Use** | | | | | | | | | | | | | | | | | |
| Is substance abuse a contributing factor: Yes No Explain:  Vital Signs: BP: \_\_\_\_ Temp: \_\_\_\_ Resp: \_\_\_ Pulse: \_\_\_ | | | | | | | | | | | | | | | | | |
| **Current Psychotropic medications** | | | **Dosage** | | | | | | **Schedule** | | | | **Route** | | | | **Start Date** |
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| Med Compliant: Yes No  **Labs:** Click here to enter text. | | | | | | | | | | | | | | | | | |
| **DSM Diagnostic Impressions** | | | | | | | | | | | | | | | | | |
| Primary: Click here to enter text. | | | | | | | | | | | | | | | | | |
| Secondary: Click here to enter text. | | | | | | | | | | Other: Click here to enter text. | | | | | | | |
| Other: Click here to enter text. | | | | | | | | | | Medical Issues: Click here to enter text. | | | | | | | |
| **Special Population:** SED SPMI SMI IDD  Pregnant using substances BH and SUD BH and IV user | | | | | | | | | | | | | | | | | |
| Treatment Objectives: Click here to enter text. | | | | | | | | | | | | | | | | | |
| Discharge plan: Click here to enter text. | | | | | | | | | | | | | | | | | |
| Expected length of stay: Click here to enter text. | | | | | | | | | | | | | | | | | |

**Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**