Patient Name: _____ Last 4 #SS_____

VAMC COATESVILLE
Inpatient Acute Psychiatry Preadmission Referral Form

Once completed by the referring facility, this form must be faxed to the appropriate receiving location:

Mon – Fri 8am-3:30pm	3:30pm-8am Mon – Fri, weekends/holidays
CVAMC Admissions Office (11Adm) 1400 Blackhorse Hill Road Coatesville, PA 19320 Telephone No. 610-384-7711, x2911/x2902 Fax No. 610-466-2226	CVAMC Urgent Care Area (111) 1400 Blackhorse Hill Road Coatesville, PA 19320 Telephone no. 610-384-7711, x4290 Fax no. 610-466-2210

Please provide your contact information to expedite processing, and allow 24 hours for your application to be processed before calling the admissions office at the number listed above.

Date of Referral :_____

Desired Date of Admission: _____

Veteran's Name: _____

SSN # _____

DOB:_____

Gulf War or Combat Veteran: **Yes** _____ **No** _____
Combat Service: _____
Period of Service: _____

Active Duty Soldier: **Yes** _____ **No** _____
If Yes, Please indicate the name and contact number of Approving Official/Commanding Officer:

_____ _____
Name **Telephone #**

Patient NOK: _____ **Contact telephone no:** _____

Patient POA: _____ **Contact telephone no:** _____

Name of Patient Fiduciary (if applicable): _____

Name of Referring Provider:_____

Contact Telephone Name: _____

Name of Referring Facility: _____

Mode of Transportation: _____

Patient Name: _____ Last 4 #SS_____

Reason for Referral/Admission:

_____
_____
_____
_____

Current Medical Status:

Medical Diagnosis(es):

_____
_____

Medical procedures in the preceding 72 hours:

_____
_____
_____

Course of Treatment to date:

_____
_____
_____

Current Medications:

_____
_____
_____

Is veteran severely visually impaired or blind? Yes____ No____

Present or history of MRSA/VRE or other infectious disease: Yes____ No____
Name of Organism(s)_____

Need/Use of continuous O2? **Yes_____ No_____**
Need/Use of O2/CPAP? **Yes_____ No_____**
Capability to perform all ADLs? **Yes_____ No_____**
Incontinence? **Yes_____ No_____**
Completely ambulatory? **Yes_____ No_____**
If No, means of ambulation _____
_____

Wound precautions? **Yes_____ No _____**
If Yes, explain_____
_____

Respiratory precautions? **Yes _____ No _____**
If Yes, explain_____
_____

Evidence of active TB? **Yes ____ No _____**

Patient Name: _____ Last 4 #SS_____

Current Psychiatric Status

Psychiatric Diagnosis(es): (to include mental health, drug and alcohol)

_____

_____

Current Suicidal Ideation? Please Describe.

_____

_____

_____

Any Suicide Attempt within the last 30 days? Please Describe.

_____

_____

_____

Any acts of violence in the last 30 days? Please Describe.

_____

_____

_____

Psychiatric Hospitalization History (include most current):

Reason:

Dates:

Treating Facility(s):

Substance Abuse Treatment History (include most current):

Substance of Choice:

Dates:

Treating Facility(s):

Current legal issues (fines tickets, violations, parole/probation, warrants, PFAs, pending charges):

_____

_____

List Any Allergies: _____

_____

_____

Current residence: _____
Is this a safe, sober environment? (Y/N) _____

Residence when acute psychiatric care is completed_____

Contact person/Facility who will arrange post-acute psychiatric stabilization:

NAME	**FACILITY**	**PHONE**

Patient Name: _____ Last 4 #SS_____

Current Drug/Alcohol Use

Name of Substance	Amount	Route	Date Last Used

Respond to the following with a Yes or No, For any No responses, please provide a comment at the end of the page:	YES	NO
Patient is stable for transfer?		
Patient is medically cleared for inpatient psychiatric hospitalization?		
Patient is voluntarily agreeing to admission and provided signed consent?		
Patient is currently on a court ordered commitment?		
Patient has been notified of transfer?		
Patient has provided consent for transfer?		
**Contraband check completed?		

**Please describe items found during the Contraband Check to include RX or non-RX medications, any sharp objects, personal items, weapons, etc.

_____

_____

_____

(√) Check list of all pertinent Patient Records to be Attached w/this referral:	√
Documentation of medical clearance for acute psychiatric hospitalization	
A copy of all Psychiatric admission notes by Psychiatrist	
A copy of all nursing notes since date of admission	
A copy of vital signs for the preceding 72 hrs.	
A copy of most recent History and Physical	
A copy of the Advance Directive and/or DNR (if applicable)	
A copy of Medication Active Inpatient/Outpatient Medication List:	
A copy of Imaging Reports **(to include EKG results)	
A copy of recent labs **(to include Chem-14, UDS, and CBC w/Diff)	
A copy of signed/witnessed 201 Voluntary Consent for Treatment Form:	
A copy of court ordered records (if patient is on a court ordered commitment)	

Additional comments:

_____

_____

_____

_____

_____