PRE-ADMISSION REFERRAL FORM

PRE-ADMISSION REFERRAL FORM PLEASE PROVIDE THIS COMPLETED FORM AND ALL REQUIRED INFORMATION TO OUR SECURE EMAIL TO THE FOLLOWING; The ADMINISTRATOR HOLLY ROYCE, HOLLY@ECRC.info and The ASSISTANT MANAGER, KENDRA HUFF, KENDRA@ECRC.info or SEND A SECURE FAX TO 928-255-1741. If you have any questions please call 928-255-1747 and speak to Holly Royce, our Administrator.

ALL REFERRALS WILL BE REVIEWED AND RESPONDED TO WITHIN 48 BUSINESS HOURS

All clients must meet the following criteria for admission and/or readmission into Exclusive Certified Residential Care, LLC:

- Be at least 18 years of age;
- Must be diagnosed with a Serious Mental Illness (SMI) or a Mental Health Disorder with a Behavioral Health Diagnosis and/or Acute Substance Abuse Disorder;
- Is **not** a sex offender;
- Demonstrate a willingness to participate in Level II Residential Treatment;

Date of Referral: ___________________________ **Date of admission requested:** ______________________

Client Name: ___________________________ **DOB:** ___/___/_____ **Phone Number:** ____________________

Social Security #: _____________________________ **Client AHCCCS ID #:** _____________________________

Behavioral Health Insurance Coverage: Insurance Company Name __________________________________

Care 1st client's require a per-authorization for Inpatient Level II services prior to client's admission to E.C.R.C.

Address (Coinciding with the client AHCCCS ID): ____

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Diagnosis Code(s) ICD-10:

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SSI / SSDI Benefits: _______ **Amount:** $_____________ **Food Assistance:** _______**Amount:** $ ______________

Payee Contact information: (If applicable)

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EMERGENCY CONTACT INFORMATION

Name: ___________________________ **Relationship:** ___________________**Contact No:** ____________________

Address: ____

Clients Parent, Guardian, or Custodian: __________________________ **Phone:** ____________________________

PCP INFORMATION

Client's Medical PCP Name: ____________________________ **Doctor's Name:** ____________________________

Date of last appointment: ________________________ **Date of next appointment:** ________________________

Phone: _______________________________________ **Fax:** ____

Address: ____

PROVIDING AGENCY INFORMATION

Client's Case Manager's or Substance Abuse Counselor's Name: ____

Date of last appointment: ________________________ **Date of next appointment:** ________________________

Best Contact Phone Number: _____________________________ **Email Address:** ___________________________

Reason for Referral: ____

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PHARMACY INFORMATION

Client's Pharmacy Name: __________________________________ **Phone:** _________________________________

Pharmacy Address: ____

Upon admission, all the client's medications must include minimum of 30-day supply or a refill ready to pick up at a local pharmacy.

REQUIRED DOCUMENTATION

Must be submitted with this Referral

- Behavioral Health Assessment - to include a description of the clients' presenting issue; identification of client's behavioral health symptoms and each behavior issue that requires treatment; description of medical symptoms reported by the client and medical referrals needed by the client, if any; recommendations for further assessment or examination of client's needs. The signature, of the professional whom conducted the assessment and the credentials and job title.

- Substance Abuse Assessment - to include a description of the clients' presenting issue; identification of client's behavioral health symptoms and each behavior issue that requires treatment; description of medical symptoms reported by the client and medical referrals needed by the client, if any; recommendations for further assessment or examination of client's needs. The signature, of the professional whom conducted the assessment and the credentials and job title.

- Current Behavioral Crisis Plan completed within the last 3 months

- Physical Exam completed by PCP / NP completed within the last 3 months

- Documentation of the screening for Infectious Pulmonary Tuberculosis, (TB Test) with a negative result completed within the last 6 months

- Documentation of any allergies, medications, food, other, if applicable

- Current medication list including Psychiatric and PCP prescriptions, if applicable

- Documentation of Client's Healthcare Directives, if applicable

- A copy of documentation signed and dated by client or (if applicable) the clients, parent, guardian or agent indicating receipt of information under R9-10-712, if applicable

- A copy of the client informed Consent to Treat

- If the Client is **Title 36**, please include a copy of the court order with this referral, this is ***mandatory***.

- Are there any additional Examinations and/or Assessments? ◯ **Yes** ◯ **No**
  If yes, please provide a copy with this referral package.

COMMENT SECTION

Please use this area for any comments or pertinent information regarding the client that would be instrumental to the clients Level II Care provided by Exclusive Certified Residential Care:

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Person submitting referral:

_____________________________________ _____________________________________

Printed Name **Date** **Signature** **Date**

Referring Agency: ______________________________ **Email Address:** ______________________________

Telephone #:______________________________ **Fax #:** ______________________________

Thank you for your referral to E.C.R.C.