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 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): _____

_____

Diagnosis Code(s) ICD-10:

_____

_____

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: _____

_____

_____

_____

_____

_____

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.

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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.

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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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_____

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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.

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