Merakey Behavioral Health
Extended Acute Care (EAC) Program
5920 Sullivan Trail
Nazareth, PA 18064

REFERRAL PACKET REQUIREMENTS

Please refer to the following in order to adhere to the standard requirements for the referral packet submission to Merakey EAC:

Referring Facility

PERSONAL INFORMATION:
- ☐ Copy of insurance cards
- ☐ Copy of Social Security Card
- ☐ Driver's License or Photo ID

LEGAL:
- ☐ Copies of commitments (Voluntary and Involuntary)
- ☐ Guardianship papers (if applicable)
- ☐ Advanced Directive (if applicable)
- ☐ Information regarding any legal issues (e.g. probation, parole, etc…)

PSYCHIATRY REPORTS:
- ☐ Psychiatric Evaluation
- ☐ Psychiatric Treatment History
- ☐ Psychosocial Assessment
- ☐ Psychiatric Discharge Summary **

REFERRAL:
- ☐ Extended Acute Care Unit Admission Referral Form (see attachment)
- ☐ Magellan Pre-Certification Completed
- ☐ Level of Care completed by ACT

MEDICAL REPORT:
- ☐ Physical Exam
- ☐ Urinalysis
- ☐ Blood work: CBC, CMP, TSH, any levels done for depakote, lithium, tegretol, etc…
- ☐ PPD results or chest X-ray *
- ☐ EKG Results *
- ☐ Medical History and Current Medical Assessment
- ☐ Current medications
- ☐ Completion of the Drug and Alcohol Assessment Form
- ☐ First week of the individual's admission progress notes and the individual's current notes prior to filling out this referral. **

These items are absolutely necessary for intake

****Please be advised if patient is accepted we will need current notes.***

Extended Acute Care Contacts

Community Planning Assessments

Provider	Contact	Phone Number
LV ACT	Sue Acklen	610-882-1355
Merakey Behavioral Health	Alina Psitos	610-866-8331
Horizon House	Jennifer Amaral	610-841-4144

ALL REFERRALS ARE TO BE FAXED TO APPROPRIATE COUNTY, ACT (FOR NC RESIDENTS), AND Merakey

Provider	Contact	Phone Number	Fax Number
Merakey EAC	Kelli Hall	610-759-1960	610-759-1961
Northampton County *Northampton County Residents	Sophia Harbove	610-829-4827	610-974-7596
CMP County *Carbon, Monroe, Pike Residents	Brian Snyder	610-377-0773 x3626	610-377-5003
Magellan *HealthChoices Consumers	Carl Kist	610-814-8012	866-382-1258

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Demographic information

		MA#	
Date of Birth:		**Admission Date:**	
Social Security #:		**Gender:**	
Height:		**Race:**	
Weight:		**Ethnicity:**	
Identifying Marks:		**Eye Color:**	
Primary Language:		**Religion:**	

Guardian Info	Name:	Phone:	
	Address:		
Emergency Contact	Name:	Phone:	
	Address:		
PCP	Name:	Phone:	
	Address:		
Psychiatrist	Name:	Phone:	
	Address:		
Rep Payee	Name:	Phone:	
	Address:		

Primary Insurance		**Secondary Insurance**	
ID#		**ID#**	
Group#		**Group#**	
Location of Card		***Location of Card***	

Allergies (Dietary, Medicine):	**Diagnosis:**

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REFERRAL FORM

Date of Referral: _____

PERSONAL INFORMATION:

Individual/Patient Name: _____ DOB: _____ Age: _____

Commitment Status: 201 / 303 / 304 / 305 Next MH Hearing: _____

SS#_____ Do you have a copy of SS card? ☐Yes (please enclose copy)

☐No Where is the copy? _____

Does individual have a DL/state ID? ☐Yes ☐No If yes DL# _____ State: ____

Exp. Date? ____ Do you have a copy of DL? ☐Yes (please enclose) ☐No Location? _____

Is there a Birth Certificate? ☐Yes ☐No Enclose copy Birth Certificate or location of BC? _____

Race _____ Sex: ☐M ☐F Ethnicity: ☐Hispanic ☐Non-Hispanic

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated

Language spoken: _____ Any language barriers? _____

Employed? _____ Employer _____

Does the patient receive SSI/SSD? ☐Yes ☐No How much? _____

Has Social Security been notified that the patient is in the hospital? ☐Yes ☐No

(Social Security needs to be notified when pts. are admitted so checks are not issued).

Access Card? ☐Yes ☐No Location of Card? _____

Managed Health Care Card (Amerihealth, Gateway, etc.)? ☐Yes ☐No Location of Card? _____

Medicare Card? ☐Yes ☐No Location of Card? _____

Is there a Rep Payee? ☐Yes ☐No If Yes, Rep Payee Name _____ Phone # _____

County MH/MR Program (circle one): Northampton Monroe Pike Carbon

Is there an ICM or ACT team involved? ☐Yes ☐No

Name:_____ phone:_____

Living Arrangements Prior to IP Treatment: _____

Anticipated Living Arrangement at Discharge from EAC (if admitted in EAC):

_____

Current Hospital (referring):_____ Date of Admission: _____

Address: _____

Contact Person at current Hospital _____ Phone_____

Email _____ Fax # _____

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INSURANCE INFORMATION:

Primary Insurance Name:_____ ID #:_____

(If Medicare how many days do they have left?_____)

Secondary Insurance Name:_____ ID #:_____

Please enclose ALL copies of insurance cards.

IF MA eligible has the application been submitted? ☐Yes ☐No Date application? _____

OUTPATIENT PROVIDERS:

Primary Care Physician:_____ Phone:_____

Psychiatrist:_____ Phone:_____

Dentist: _____ Phone: _____

OB/GYN _____ Phone: _____

Specialist _____ Phone: _____

Specialist _____ Phone: _____

(E.g. eye, endocrinologist, neurologist, dermatologist, etc.)

COMMUNITY SUPPORTS:

Emergency Contact Person: _____ Relationship: _____

Address:_____

Phone: _____ Does this person have a guardianship? ☐Yes ☐No

If yes, please enclose copy of the guardianship papers.

Is there another person that is the guardian? ☐Yes ☐No

Name _____ Phone _____

Besides the Emergency Contact who else are the Formal and Informal Supports:

Name	Relationship	Phone	Frequency of Contact
	Any sponsor?		

Are they a Clubhouse/Lodge/Daybreak member? ☐Yes ☐No
Where? _____

PREVIOUS MENTAL HEALTH ADMISSIONS:

Please list acute, extended, or state hospitalizations in the past 5 years:

Hospital	Dates	Admission DX

CURRENT DIAGNOSIS AND MEDICAL INFORMATION:

Axis I_____

Axis II_____

Axis III_____

Axis IV_____

Axis V_____

Medical Diagnosis/Concerns: _____
Was TB test done? ☐Yes ☐No Date? _____
Flu shot done? ☐Yes ☐No Date? _____

Is the person participating in group therapy? ☐Yes ☐No

Violence/Assaultive Behavior History: ☐Yes ☐No (If yes, please describe known history)

_____

_____

_____

Any fire setting history? ☐Yes ☐No Explain: _____
Was the patient ever placed in physical restraints? ☐Yes ☐No
Any recent restraints in current hospital? ☐Yes ☐No Last Date? _____

LEGAL:

Involvement with criminal justice system? ☐Yes ☐No
If yes, please provide additional information including probation/parole, pending charges, or history of incarceration.

_____

_____

_____

Are they on parole/probation? ☐Yes ☐No (If yes, please provide name)
Officer_____ Phone# _____

MEDICATIONS:
****ATTACH LIST OF CURRENT MEDICATIONS.

If on clozaril when did it start and what is the current dose? _____
If on depakote/lithium/tegretol, what are the most recent lab levels? _____

Below please list Medications that have been tried and were not successful.

_____

_____

SYMPTOM CHECKLIST

Using the following scale, indicate the severity of each symptom: (1) = at admission (2) = at present

	(1)	(2)		(1)	(2)		(1)	(2)
Anxious			Hallucinations, type:			Paranoia		
Assaultive Behavior						Poor Impulse Control		
Bizarre Behavior			Homicidal			Psychomotor Agitation		
Blunted Affect			Hostility			Psychomotor Retardation		
Depressed Mood			Hypomania			Self-Mutilation Behavior		
Disorganization			Intrusiveness			Sexual Acting Out Behavior		
Disorientation			Mania			Sexual Preoccupation		
Delusions			Med Non-compliance			Somatic Concerns		
Emotional Withdrawal			Needs Assist with ADL			Suicidality		
Excitability			Needs Restraints/Seclusion			Suspiciousness		
Grandiosity						Uncooperativeness		

Has the patient been or is the patient currently a 1:1? ☐Yes ☐No Last date? _____
For how long? _____ Why? _____
Has the patient been given IM PRNs? ☐Yes ☐No Last date? _____

Special Needs (ambulation, dietary, dentures, vision/hearing impairments):

Advanced Directive/Living Will: ☐ Medical ☐Psychiatric
Please send copies of all Advanced Directives and Commitments

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EAC DRUG AND ALCOHOL ASSESSMENT FORM

List all illegal drugs, inhalants, alcohol, misused prescription / non-prescription [illegible] performance enhancers, caffeine:								
Substance	How Taken	Age 1st Use	Age Regular Use	Present Use Pattern	Date Of Last Use	Withdrawal Symptoms Yes/No	Describe withdrawal symptoms	[illegible]

Is there a sponsor? ☐Yes ☐No Name ______________________________

List physical symptoms from substance used:

____

Please note any psychological or behavioral effects of the substance used:

____

____

Please note any support groups or other supports used in prior attempts to achieve stability:

____

____

_______________________________________ ____________________

Signature: Staff Completing Form with Credentials Date

_______________________________________ ____________________

Signature: County Representative signifying approval Date