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

<table>
<thead>
<tr>
<th>Provider</th>
<th>Contact</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>LV ACT</td>
<td>Sue Acklen</td>
<td>610-882-1355</td>
</tr>
<tr>
<td>Merakey Behavioral Health</td>
<td>Alina Psitos</td>
<td>610-866-8331</td>
</tr>
<tr>
<td>Horizon House</td>
<td>Jennifer Amaral</td>
<td>610-841-4144</td>
</tr>
</tbody>
</table>

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

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

Form # 09371 N: 7/2010.
Demographic information

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
ID# ____________________________  ID# ____________________________
Group# ____________________________  Group# ____________________________
*Location of Card* ____________________________  *Location of Card* ____________________________

Secondary Insurance

Allergies (Dietary, Medicine): ____________________________

Diagnosis: ____________________________

Form # 09371  N: 7/2010
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: ___________________________ Phone: ___________________________
Contact Person at current Hospital ___________________________ Phone ________
Email ___________________________ Fax #: ___________________________
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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
<th>Frequency of Contact</th>
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</table>

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:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Dates</th>
<th>Admission DX</th>
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<tbody>
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</tbody>
</table>

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#____________________

Form # 09371  N: 7/2010
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

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

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

Form # 09371 N: 7/2010
**EAC DRUG AND ALCOHOL ASSESSMENT FORM**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Last Taken</th>
<th>Age</th>
<th>Sex</th>
<th>Normal Use</th>
<th>Date Of Crash</th>
<th>RoF</th>
<th>Halluc.</th>
<th>Withdrawal Symptoms</th>
</tr>
</thead>
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Is there a sponsor? □ Yes □ No Name __________________

List physical symptoms from substance use:

________________________

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

________________________

Effects noted in support groups are only supportive of prior problems and may not stabilize:

________________________

Signature: Staff Completing Form with Credentials ______________________ Date

Signature: County Representative signifying approval ______________________ Date