CLARION
PSYCHIATRIC CENTER

☐ **Direct Admission** ☐ **Scheduled Assessment** ☐ **Walk-In**

Initial Contact Sheet **CALL ENTERED: _____**

TIME: _____DATE: ____/____/_____ CALL RECEIVED BY: _____
(Signature Required on Reverse)

REFERRAL DATA: (Who Suggested CPC? How did they access our phone number?)

(CALLER) FIRST NAME: _____ LAST NAME: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: ____ _____-_____-_____

REFERRAL NAME: _____ AGENCY: _____

PATIENT INFORMATION **Preferred Language: ☐ English ☐ Other: _____**

FIRST NAME: _____ MI: ____ LAST NAME: _____

AGE: ____ D.O.B: ____/_____/_____ GENDER: □ Male □ Female **SSN#: _____-_____-_____**

ADDRESS:_____

CITY:_____ **STATE**: _____ **ZIP CODE**: _____ **COUNTY:**_____

PHONE NUMBER: _____ -_____ -_____ **Gender Identity: ☐ Male ☐ Female**

COMMITMENT STATUS: ◯ 201 ◯ 302 ◯ 303 ◯ 304 ◯ ACT 147 ◯ OTHER:_____

PRESENTING PROBLEM: (Make sure to assess acuity/safety for all assessment calls)

□ ***Suicidal*** □ ***Self-Harm*** □ ***Homicidal/Assaultive*** □ ***Psychosis***

_____

_____

_____

_____

Access to Lethal Means:_____

Substance Misuse (What, How Much, How Often, Last Use):_____

Previous Inpatient Tx: _____

Current Outpatient: _____

Medical Concerns: _____

Was an HCG (pregnancy test) completed, if pt is female? □ Yes □ No □ N/A (If no, Explain :_____)

HCG Results: □ Positive □Negative □N/A

Is the client diagnosed with an intellectual disability? □ Yes □ No IQ: _____

Is the client a sexual victim? □ Yes □ No □ N/A _____

Is there concern for sexual aggression/preoccupation? □ Yes □ No□ N/A _____

******Allergies:*** _____

Vitals on Assessment: B/P: _____ T: _____ P: _____ R: _____ ☐ Not Obtained

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Current Medications	Dosage	Frequency
□ N/A		

Is the patient medically stable for transfer to CPC? ☐ Yes ☐ No ☐ N/A
Nurse Reviewing Intake Paperwork if applicable: _____

Military Status?
☐ Yes ☐ No

Primary Insurance □ *Precertification Complete*
Name: _____ Phone Number: _____-_____-_____

Secondary Insurance □ *Precertification Complete*
Name: _____ Phone Number: _____-_____-_____

Does anyone have Medical/Educational Rights over the patient? □ Yes □ No (list below)
Does anyone have Guardianship? □ Yes □ No (list below)
Does anyone have Power of Attorney? □ Yes □ No (list below)

First Name: _____ Last Name: _____
Relationship: _____ Phone Number: _____-_____-_____

Who is the patient's emergency contact? □ Same as above

First Name: _____ Last Name: _____
Relationship: _____ Phone Number: _____-_____-_____

Scheduled Assessment ~ Date: ____/____/_____ Time: _____

If Caller is a Referral Source Proceed as a Direct Admission ~ Faxing Labs? □ Yes □ No □ N/A
Fax # 814-226-9097

Physician On-Call: _____ Nurse Notified: _____
Time Accepted: _____ □ N/A

Admitting Psychiatric Diagnosis: _____
_____

Medical Diagnosis: _____

Transportation? □ CPC □ Ambulance □ Constable □ Private Vehicle □ Other: _____

Staff Reviewing with Physician: _____

Notes: _____
_____
_____

Information Collected By:_____ _____ _____
(Signature) (Date) (Time)