HORIZON HEALTH | 40 Years of Behavioral Healthcare Solutions

INTAKE/INQUIRY FORM

INQUIRY: Date _____ **Time** _____ **Completed By:** _____

Caller Name/Title: _____ **Phone #:** _____

Company: _____ **Address:** _____

Patient Referred By: _____ **Primary MD** _____ **Tel #** _____

Patient Resides at: SNF ☐ Home ☐ Group Home ☐ Assisted Living ☐ Other ☐ _____

PART A: PATIENT INFORMATION

Patient Name _____ **DOB** _____ **Male** ☐ **Female** ☐ **Other** ☐

Address _____ **City** _____ **County** _____ **Zip** _____

Insurance: **Primary** _____ **#** _____ **Secondary** _____ **#** _____

SSN # _____ **DPOA/Guardian/Family Name** _____ **Phone** _____

Can the patient answer the three (3) questions below to establish capacity to consent for admission as a voluntary patient?

Who are you?☐ **Where are you?**☐ **Why are you here?**☐

PART B: PRE-ADMISSION SCREENING

PART B & C Completed By: _____ **Date/Time** _____

REASON FOR REFERRAL

ADMISSION CRITERIA: ***Check all that apply***

	Suicidal Ideation/plan/attempt		Acute severe exacerbation of chronic symptoms
	Requires intensive follow-up		Assaultive destructive behavior/assaultive/poor impulse control
	Risk due to disorientation/impairment		Medication withdrawal change toxic effects or non-compliance
	Failed less intensive level of care		Psychiatric symptoms severe causing bizarre disordered behavior
	Sleep/nutrition disturbance poses risk		Other: *Describe:*

Current Medical Condition(s): _____

Medically Cleared by: _____

Medications (Include Non-Prescription)

PART C: DISPOSITION AND STATUS

Date: _____ **Time:** _____

Please check the box(s) that apply

	General information only		Ref. source chose another facility		Administrative denial		Census cap staffing
	Clinical admission criteria not met		Failed to keep appointment		At baseline functioning		Census cap/environment
	Medically unstable		Non-participating PPO/HMO		Physician declined to admit		Census cap/other
	Pt/family refused		Unable to follow up		Age inappropriate		Consult in hospital
	Pt/family chose another facility		No space available: ***current census #***		Not appropriate for milieu		Other:

Referral Instructions:

Admission Date _____ **Time** _____ **Voluntary** ☐ **Involuntary** ☐

Authorizing Physician _____ **Time** _____ **Attending Physician** _____

Patient Label _____ **Review Date** _____ **Time** _____ **PD Signature** _____