Referral Criteria

Turning Point 900 Early Street, Sac City, Iowa **PH: 712-662-8055 FX: 712-662-8054**
Cell: 712-661-8000

Turning Point is a facility that will provide short term crisis stabilization residential services (3 to 5 days stay) to individuals who are 18 years of age or older, meet mental health crisis criteria and are not in need of inpatient mental health treatment. Referrals will be screened by an Emergency Department physician, local physician, or a mental health professional to deem that they are medically stable and in a state of mental health crisis.

At least one of the following criteria may prohibit the individual from admittance:

- Acute medical condition – Note: individual may be monitored and screened for later acceptance of admission.
- Physical disability preventing consumer to care for self
- Actively psychotic
- Sex offender
- Actively suicidal and or homicidal: do they have a plan or the means?
- Active self-injurious behavior in the past 24hrs
- High risk behavior of violence
- Over the legal alcohol limit; may admit after a lab test showing under the legal limit.
- Currently detoxing due to alcohol

Referral Information

Name: _____ Preferred name: _____

DOB: _____ SSN#:_____ PH: _____

Address: _____County:_____

Legal Guardian or Power of Attorney? Yes _____ No ___ If Yes, Who: _____

Emergency Contact Name & PH: _____

MCO/Medicaid #: _____ Other Insurance: _____

Sex: _____ Sexual Orientation: _____Gender Identity: _____ Preferred Pronouns:_____
Race: _____ Military Y/N: _____ Marital Status: _____

Religious & Cultural preferences & needs (food, routines, etc.): _____

Please describe impairments that are occurring due to mental health symptoms:_____

_____

_____

_____

_____

History

Mental Health Illness: Yes_____ No ____ If yes, List Diagnosis: _____

Currently receiving outpatient psychiatric treatment?

Yes ___ No ___ If yes, Name of Provider & Agency: _____

Currently have a Case Manager, Integrated Health Home worker, or DHS case worker?

Yes ___ No ____ If yes, Name of Worker & Location: _____

Check all the following behaviors that apply:

____ Manic Behavior ____ Threatening Others ____ Paranoia

____ Borderline Traits ____ Auditory Hallucination ____ Aggressive Behavior

____ Visual Hallucinations ____ Depression ____ Anxiety

____ Self-Harm ____ Isolated or Withdrawn ____ Sexual Problems

____ **Suicidal Ideation**, Plan _____

If individual presents with suicidal ideation, please answer the following questions:

- Have there been prior attempts of suicide? ____ Yes ____ No If Yes, how many attempts? _____
- Method and date of last attempt? _____ Hospitalization required? _____ Yes _____No
- Has the individual ever received inpatient treatment for mental health? ____ Yes ____ No
- If yes, where and when _____

____ **Homicidal Ideation**, Plan _____

If individual presents homicidal ideation, please answer the following questions:

- Current indicators of risk:
  ____ Makes threatening comments ____ Makes threatening comments to intended victim
  ____Engages in threatening behavior ____ History of aggressive behavior and poor impulse control
  ____ History and/or current domestic or familial violence issues
  ____ Prior acts of violence
- If yes to any of the above, date of most recent episode/act: _____

____ **Sexually Inappropriate Behavior**. If the individual presents with sexually inappropriate behavior, please answer the following questions:

- Current indicators of risk:
  ____ Makes threatening gestures
  ____ Makes sexually inappropriate comments to intended victim
  ____ Engages in sexually inappropriate behavior
  ____ History of aggressive behavior and poor impulse control
  ____ Prior acts of sexually inappropriate/aggressive/assaultive behavior

SUBSTANCE USE SCREENING: *Please ask the individual the following.*

The last time they used in the past month	Not at all	1-3 days	3 days or more
Any type of alcohol (beer, liquor, wine)			
Marijuana			
Methamphetamines			
Cocaine			
Heroine			
Ecstasy			
Inhalants (fluids, gasoline, lighters, paint)			
Prescription drug abuse (Xanax, OxyCotin, Vicodin, Codeine)			
OTC medication abuse			

- Have you ever been treated for substance abuse on an inpatient or outpatient basis? ____ Yes ____ No
- If yes, where and when? _____
- Have you been or are you experiencing any of the following symptoms due to withdrawal from substances?

____ Shaking hands ____ Vomiting or stomach cramps ____ Fever ____ Hallucinations

____ Fainting ____ Irritation ____ Other withdrawal symptoms

Please attach a list all prescribed and over-the-counter medication the individual is currently taking. Include recently stopped medications.

Name of Current Pharmacy: _____

List any pertinent medical information, discharge planning, follow-up information:_____
_____
_____
_____
_____
_____
_____
_____
_____

Provide the following list of clinical information:

- History & Physical or most recent Primary Care Physician Note
- Psychiatric Evaluation and supporting documentation, if applicable

The purpose of acute crisis residential stabilization services has been explained to me and I voluntarily choose to participate.

Individual Signature: _____ Date: _____

I have reviewed the material and it is my professional opinion that the individual is appropriate for acute crisis stabilization residential services at Turning Point.

Referring Provider & Agency Signature: _____Print Name:_____
Date: _____