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.
* Inability to complete activities of daily living by self (toileting, showering, dressing, grooming, etc.)
* Sex offender
* 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 preference and 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

\_\_\_\_ Current and/or History of Eating Disorder \_\_\_\_ Current and/or History of Pica

\_\_\_\_ **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, if applicable
* 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: