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| --- | --- |
| **Member Demographics**   |  |
| Last Name Click here to enter text.  | First Name Click here to enter text.  | MI \_\_\_ | Beneficiary ID: Click here to enter text.  |
| Admission Date: Click here to enter a date. |
| Completed by: Click here to enter text.  | Admission TIME: \_\_\_ [ ] AM [ ] PM  |
| Date of birth: Click here to enter a date. | Age: \_\_\_ Gender: \_\_\_  | Telephone #: Click here to enter text. |
| Address/Street  Click here to enter text.  |  Apt. #  \_\_\_  | City Click here to enter text. | CountyClick here to enter text. | StateKS | ZipClick here to enter text. |
| Other Health Insurance? [ ] Yes [ ]  No If yes specify:CMHC Responsibility: Choose an item.Member Status: Choose an item. |
| **Admission Type:** [ ] **Acute** [ ] **PRTF** [ ] **State Hosp Alt**  [ ] **Wheatland** [ ]  **Prairie Ridge** [ ] **State Hospital** |
| Facility Name: Click here to enter text. |
| Address/Street Click here to enter text.  |  City Click here to enter text.  | State KS | Zip Click here to enter text. |
| Facility ID: Click here to enter text. | Facility NPI #: Click here to enter text. |
| Facility telephone #: Click here to enter text. | Fax #: Click here to enter text. |
| Attending Physician name:Click here to enter text. | Telephone #: Click here to enter text. |
| Facility UM Reviewer: Click here to enter text. | Telephone #: Click here to enter text. |
| **Admission Assessment** [ ]  **Voluntary** [ ]  **Involuntary** |
| Circumstances of admission: (Outpatient referral, ER, MFT, transfer from ICU, Medical, self-referral, other)Click here to enter text. |
| Specify current symptoms and behaviors that require hospitalization: Click here to enter text. |
| Results of lethality assessment: (describe current plan and level of intent)[ ] Suicide Ideation [ ] Active SI [ ] Passive SI[ ] Homicidal Ideation [ ] Active HI [ ] Passive HIMeans to carry out plan: Click here to enter text.Member’s current frame of mind: (feeling justified in attempt, disappointment in failed attempt, etc.) Click here to enter text. |
| **Current Legal Status**  |
| Currently on Supervision: [ ] Yes [ ]  No If yes specify: Custody: Choose an item.Name of Contractor: Click here to enter text.Dates of Custody: From: Click here to enter a date. To: Click here to enter a date. |
| **Current**  |
| Current Mental status exam: (Current symptoms of distress or dysfunction, appearance, behavior, orientation, thought process/content, affect mood, memory, psycho motor status, judgment, impulse control, etc.)Click here to enter text. |
| Current Services: Click here to enter text. |
| Current living arrangement, support system, psycho social stressors, history of abuse/trauma:Click here to enter text. |
| **Historical** |
| Previous SI/HI attempts: Click here to enter text. |
| History of prior inpatient psychiatric hospitalizations: Click here to enter text. |
| **Substance Use** |
| Is substance abuse a contributing factor: [ ] Yes [ ] No Explain: Vital Signs: BP: \_\_\_\_ Temp: \_\_\_\_ Resp: \_\_\_ Pulse: \_\_\_ |
| **Current Psychotropic medications** | **Dosage** | **Schedule** | **Route** | **Start Date** |
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| Med Compliant: [ ] Yes [ ] No **Labs:** Click here to enter text. |
| **DSM Diagnostic Impressions** |
| Primary: Click here to enter text. |
| Secondary: Click here to enter text. | Other: Click here to enter text. |
| Other: Click here to enter text. | Medical Issues: Click here to enter text. |
| **Special Population:** [ ] SED [ ] SPMI [ ] SMI [ ] IDD [ ] Pregnant using substances [ ] BH and SUD [ ] BH and IV user |
| Treatment Objectives: Click here to enter text.  |
| Discharge plan: Click here to enter text. |
| Expected length of stay: Click here to enter text. |

**Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**