Senior Behavioral Health Services
Phone: 620-724-7399 Fax: 620-724-5187

Inpatient Referral

Demographics

Caller's Name: ______________________________ Relation to Pt:____

Facility Name: __________________________________ Phone #:____

Patient Name: _____________________________ Date of Birth: ___________ Age: ____ Sex: M F

Patient SS#:____________ Patient Address: ____

Healthcare DPOA/ Guardian: _____________________________________ Phone #: ___________________________

Medical Provider: ____ Phone #: ___________________________

Mental Health Provider: ____ Phone #: ___________________________

Medical & Care Assesment:

Allergies: ____

Present Infections:
- ☐ - C-dif
- ☐ - MRSA/VRE
- ☐ - Sepsis
- ☐ - UTI
- ☐ - Other: ___________________

Vaccines:
- Flu Vac: ________________
- Pneumonia Vac: __________
- Covid Vac: _______________

Covid Last 30 days:
- ☐ Yes
- ☐ No

☐ Full Code ☐ DNR

Transfers:
- ☐ - Sit-to-Stand lift
- ☐ - Hoyer Lift
- ☐ - Assistx1
- ☐ - Assistx2

Orientation:
- ☐ - Person
- ☐ - Place
- ☐ - Time
- ☐ - Situation

- ☐ - C-PAP
- ☐ - O2
- ☐ - LPM
- ☐ - Walker
- ☐ - Cane
- ☐ - Wheelchair
- ☐ - Special Utensils

ADL's
- ☐ - Independent
- ☐ - Dependent
- ☐ Assist with __________

Wounds:
- ☐ Yes Where________ Type ___________
- ☐ No

Stage if Pressure: _______ **TX** ______________________________

Last Bowel Movement: ________

Loose Stools ☐ Yes ☐ No

Recent Weight: __________

Continent:
- ☐ Yes
- ☐ No

Incontinent:
- ☐ Bowel
- ☐ Bladder

Liquids:______
- ☐ Thin
- ☐ Nectar Thick
- ☐ Honey Thick

Medication:
- ☐ Whole
- ☐ Crushed

Recent Med Change:
☐ Yes Med Changed:__________ ☐ No

Pharmacy: ______________________

Dentures:
- ☐ Yes
- ☐ No
- ☐ Upper
- ☐ Lower ☐ Full
- ☐ Partial

Hearing Aides:
- ☐ Yes
- ☐ No

Glasses:
- ☐ Yes
- ☐ No

Hx-Falls:
- ☐ Yes When ________
- ☐ No

Hospice:
- ☐ Yes DX__________
- ☐ No

Accuchecks:
- ☐ Yes
- How Often:______
- ☐ No

Tobacco: ☐ Current ☐ Quit ☐ Never How Much:_____________

Type: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Smokeless Tobacco

Alcohol Use: ☐ Yes ☐ No

Drug Use: ☐ Yes ☐ No Type:_____________

Summary of Events, Symptoms, Behaviors leading to referral:

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____
____
____

Call 620-724-7399 TO MAKE VERBAL REFERRAL -- THEN FAX THE FOLLOWING TO GMC SBH : 620-724-5187

- Completed inpatient referral form
- Current CBC & CMP / Current UA with Drug Screen (within 7 days if available)
- Facesheet
- Medication & Diagnosis List
- H&P and/or last physician / hospital visit
- Nurse's notes documenting behaviors / psych symptoms
- Healthcare DPOA / Guardian Documents
- Doctor's order for psych eval / gero psych hospital admission
- If on hospice: Will need discharge from hospice order once accepted for admission

Insurance:

Medicare ID #: ________________ Traditional __________________ Aetna _________________ Humana ____________________

UHC ________________ Allwell ___________________ BCBS __________________ KS Health Advantage ____________________

Medicaid ID #: ________________ Sunflower __________________ UHC Comm Plan __________________ UHC Aetna ___________________

Supplementary Ins: ____ ID #: ___________________________