

Reviewed by: Program Director/Medical Director		Date: ____/____/____		Time: _____	
Part A: PATIENT INFORMATION Completed by: _____ Date ____/____/____ Time _____					
Patient Name			Caller		
Age _____ DOB _____		<input type="checkbox"/> Male <input type="checkbox"/> Female		Agency	
SS# _____ - _____ - _____ Home Phone _____			Telephone #: _____		
Address: _____			Primary Physician: _____		
City _____ State _____ Zip _____		Psychiatrist: _____			
Guardianship? <input type="checkbox"/> Yes <input type="checkbox"/> No			Heard about BHS from: _____		
Name of Guardian: _____ Phone _____			Insurance: Primary <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____		
<input type="checkbox"/> Emergency assessment		<input type="checkbox"/> Information only		Secondary <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____	
<input type="checkbox"/> Routine assessment		<input type="checkbox"/> Referred to other hospital		Insurance #: _____	
<input type="checkbox"/> Admit criteria not met		<input type="checkbox"/> Admission pending			
Part B: CRITERIA FOR ADMISSION TO <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Program					
Danger to Self:					
Is the patient suicidal? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Is there a plan? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Do they have the means? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Past suicide attempts? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Danger to Others:					
Do they have assaultive behaviors? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Thoughts of harming others? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Means to harm? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Destruction of property? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Grave Disability: (Does the patient have any functional limitations, can they care for self, provide food, clothing or shelter?) _____					
A recent weight loss or gain? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Unsuccessful outpatient treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Toxic effects of psychotropic drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Withdrawal symptoms present? <input type="checkbox"/> Yes <input type="checkbox"/> No _____					
Other: _____					
Current Medical Conditions: _____					

Medical Clearance By: _____		Date: _____		Time: _____	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Yes (list) _____					
Medications (Name/dose/frequency/last taken)					

Part C: DISPOSITION AND STATUS:					
<input type="checkbox"/>	Admission Criteria Not Met	<input type="checkbox"/>	Admission Refused	<input type="checkbox"/>	Referral to:
<input type="checkbox"/>	Age Inappropriate	<input type="checkbox"/>	Admitted: <input type="checkbox"/> Voluntary	<input type="checkbox"/>	Admission to Intensive Outpatient Program
		<input type="checkbox"/>	Involuntary <input type="checkbox"/> Guardianship		
Name of Psychiatrist Contacted for Consultation/Disposition: _____				Date/Time: _____	
				<input type="checkbox"/> Consultation Form Completed	
Signature of person completing call to MD: _____					
Additional Comments: _____					



**Behavioral Health Services
Inquiry / Assessment Form**

Patient Label

