NC DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES
Regional Referral Form for Admission to an ADATC

Referral to: ☐ Crisis ☐ Detox ☐ Rehab ASAM Level: _____ Type of Admission: ☐ Voluntary ☐ Involuntary ☐ MH ☐ SA ☐ MH/SA

Name of Referral Source/Agency: _____ Contact #: _____

Consumer/Patient's Name: _____ Date of Birth: _____
Last First Middle Maiden MM/DD/YY

Other Names Used by Consumer (if applicable): _____ ***Please provide a photocopy of consumer's state-issued ID

Gender: ☐ Male ☐ Female ☐ Trans Female ☐ Trans Male ☐ Non-Binary Consumer's Ethnicity: _____

Consumer Address: _____ Phone: _____

County of Residence: _____ Additional Contact Numbers (if applicable): _____

Preferred Language: _____ Read/Write English: ☐ Yes ☐ No Is an interpreter needed? ☐ Yes ☐ No

☐ Consumer is Deaf or Hard of Hearing and uses American Sign Language as primary means of communication

Legal Guardian: _____ Relationship of Guardian to Consumer: _____

Guardian Address: _____ Phone: _____

NOTE: GUARDIANSHIP PAPERS MUST BE SUBMITTED WITH REFERRAL.

Is Consumer Currently: ☐ Suicidal ☐ Homicidal ☐ Engaging in Self-Injurious Behavior

Describe (attempts, thoughts, plans): _____

Mental Status (appearance/affect/behavior/hallucinations): _____

Current Withdrawal Symptoms: _____

SUBSTANCE USE INFORMATION: PLEASE COMPLETE FOR ALL INDIVIDUALS SUSPECTED OF SUBSTANCE USE

Substance	Route	Frequency	Date Last Used	Average Amount Used

Principal Diagnosis: _____ Req assistance with ADLs? ☐ Yes ☐ No

Behavioral Health Diagnoses: _____ Cognitive Impairment? ☐ Yes ☐ No

Medical Diagnoses: _____ Describe: _____

Medical History: ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Seizure Disorder ☐ Non-Ambulatory ☐ Asthma ☐ Hepatitis ☐ TBI
☐ Chronic Pain ☐ Recent Trauma ☐ Recent Seizure ☐ Delirium Tremens ☐ Withdrawal-Seizure ☐ Other: _____

Comments: _____

Is the consumer/patient pregnant: ☐ Yes, how many weeks: _____ ☐ No ☐ Unknown If yes, include ALL prenatal care information

Previous Medical/Psychiatric/SA Admission(s) to Any Hospital/Facility in the past 3 months (where, when, why): _____

_____

Previous Admission to a State Facility: ☐ Yes ☐ No If Yes, which: _____

Current Medications (Attach additional pages if needed for full medication list)			
Name	**Dosage**	**Name**	**Dosage**

Recent med changes: _____

Allergies/Side Effects: _____

Time Vital Signs Taken: _____ BP: _____ Pulse: _____ Resp: _____ Temp: _____ Weight: _____ (If Available)

BAC: _____ Time: _____ (If Available)

Labs Available: ☐ Yes ☐ No If Yes, please attach.

Current/Pending Legal Charges: _____

Goal of Hospitalization/Treatment Objectives/Treatment Recommendations: _____

_____

Support System			
Name	**Relationship**	**Address**	**Phone**

Discharge Plans/Placement: ☐ Home ☐ Friend/Family ☐ Community/Group Home ☐ Residential ☐ Long-Term Care ☐ Other: _____

Special Considerations Upon Discharge: _____

Additional Contacts			
	Name	**Phone**	**Fax**
Case Manager			
Therapist			
Psychiatrist			
Agency After Hours			
LME/MCO Contact			
Other Provider			

Third Party Coverage: Medicaid #: _____ Medicare #: _____ Other: _____

Insurance Company: _____ Policy Holder: _____ Policy Number: _____

Attach copy of insurance card if available

Veteran: ☐ Yes ☐ No Branch: _____ VA benefits? ☐ Yes ☐ No Has an authorization from a VA facility for your referral been obtained? ☐ Yes ☐ No

TRACKING NUMBER (Person referring must call LME to obtain (not avail via the portals), DO NOT COMPLETE if consumer has Standard Plan Medicaid)

Referring County: _____ Phone: _____ Responsible County: _____ Phone: _____

Tracking #: _____ From: _____ To: _____(Day not covered)

PLEASE NOTE: ANY MISSING INFORMATION MUST BE SENT TO THE ADMITTING FACILITY WITHIN ONE WORKING DAY OF THE CONSUMER'S ADMISSION.

Form completed by: _____

Signature Title Date

Insurance Verification Informed Consent

*****Referred Consumer to sign*****

I, _____ herby authorize the ADATC facility/ADATC Processing Agent, to contact my insurance carrier (shown above) to determine eligibility and to obtain authorization for medical services if required. I understand that my insurance will be billed for services rendered by the ADATC facility. I understand that I may be utilizing an "out of network" provider/ facility for services rendered.

Signature _____ Date _____

Witness _____ Date _____