



Baltimore, MD 21287

www.hopkinsmedicine.org/psychiatry

Department of Psychiatry

Referral Form for Inpatient Admissions

Referral Date: _____ Program: _____

Referring Clinician's Name, Title, and Contact Number: _____

Patient Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell: _____ Other: _____

Contact Name, Relationship, & Phone Numbers: _____

Insurance Information

Please provide front and back copies of **all** insurance cards & complete the information below.

Primary Insurance Name: _____ Mental Health Contact #: _____

Policy/Member ID Number: _____ Group Number: _____

Subscriber Name/Relationship to Patient: _____

Employer: _____

Secondary Insurance Name: _____ Mental Health Contact #: _____

Policy/Member ID Number: _____ Group Number: _____

Subscriber Name/Relationship to Patient: _____

Employer: _____

Tertiary Insurance Name: _____ Mental Health Contact #: _____

Policy/Member ID Number: _____ Group Number: _____

Subscriber Name/Relationship to Patient: _____

Employer: _____

INITIAL INTAKE ASSESSMENT

Is this referral for ECT? _____

IF YES, has the patient consented to ECT treatment? _____

Has the patient had ECT previously? If so, when and how many treatments? _____

Has the patient/family been informed the patient should not drive for 2 weeks post ECT? _____

Is the patient taking any medications that would need to be tapered prior to ECT? _____

Is there someone in the patient's support network that would be able to transport and observe the patient for outpatient ECT to taper treatment? _____

Does the physician agree to see the patient between outpatient ECT treatments, perhaps as often as weekly during the taper? _____

PAST PSYCHIATRIC HISTORY

1. Previous Inpatient: _____

Has the patient needed constant observation, a sitter or 1:1 in previous hospital stays? _____

2. Previous Outpatient: _____

3. Current Medications- Please include dosages: _____

Is there any history of medication non-compliance? _____

4. History of Suicide Attempts, Homicidal Ideation, Violence: _____

5. History of Sexual, Physical Abuse, Sexual Acting Out Behavior: _____

6. Legal History/Probation: _____

7. Family History of Psychiatric/Substance Abuses Issues: _____

8. Psychosocial history: _____

MEDICAL PROBLEMS:

Medical comorbidities: _____

Allergies: _____

Has the patient had any recent falls? If yes, please describe: _____

AFTERCARE:

What is the plan for treatment after discharge? _____

Who/what are the supports who will be involved with treatment and aftercare planning? This would include picking up patient at discharge. Please tell the family that we expect to discharge all patients at 11 AM on the day of discharge. _____

Will the patient return to their current housing? _____

Would the patient be able to attend day hospital at our facility? This would include daily trips, Monday-Friday, to Johns Hopkins Hospital. _____

