

Psychiatrist's Request for Transfer to DMH Facility

I. HOSPITAL INFORMATION

Referring Hospital: _____

Referring MD: _____

Email: _____ Phone: _____ Page/Cell: _____

Attending MD (if different from above): _____

Email: _____ Phone: _____ Page/Cell: _____

Hospital Social Worker: _____

Email: _____ Phone: _____ Page/Cell: _____

II. IDENTIFICATION

Patient Name: _____ Date: _____

Address _____
(number and street) (Apt no) (City) (State) (Zip code)

Birth Date _____ Sex _____ Race _____ Language _____ Preferred
MM/DD/YY M / F Does patient speak English? Yes No

Has authorization for DMH continuing care services already been determined for this patient? Yes No
(If "No" has application been filed? Yes No) *Please Note: an application for DMH services is required for referrals of individuals who are not already authorized to receive DMH services. However, a DMH service authorization is not necessary for a referral to be accepted and a transfer to occur.*

DMH Site Tie (if known): _____

Health Insurance

No health coverage
 Medicaid/MassHealth Card #: _____ RID #: _____
MassHealth Provider HMO _____ PCC Psych Under 21 Other
(Name of HMO)
 Medicare
 Other Insurance Name of Insurance: _____ Policy #: _____

Name of Policy Holder: _____

Diagnosis:
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Date of Inpatient Admission: _____
MM/DD/YY

Legal Status
 4 Day Hospitalization - M.G.L. c. 123, s. 12
 Conditional Voluntary Admission - M.G.L. c. 123, ss. 10 & 11
 Civil Commitment - M.G.L. c. 123, ss. 7 & 8, Exp. Date: _____
 District Court Rogers – 8b Probate Court Rogers

Other Legal Issues: _____

2. Discontinued Psychiatric Meds during this hospitalization:

Name	Highest Dose	When/Why Discontinued

VII. Medical History

1. Medical Problems:

TB: PPD Date: _____ Result: NEG: _____ POS: _____ If positive, treatment given _____
 _____ REFUSED: _____ Active Symptoms: YES: _____ NO: _____

CXR Date: _____ Result: POS: _____ NEG: _____

Diet Restrictions? ___ No ___ Yes (if yes describe): _____

Physical Limitations? ___ No ___ Yes (if yes describe): _____

2. Surgery:

3. Medical Medications: *Current Medications*

Name	Dose	Frequency	Side Effects	If Applicable Blood Level/WBC/Date*

**Last WBC & Date Required for Clozapine*

Medication Adherence?: ___ Good ___ Needs Encouragement ___ Poor

VIII. Current Involvement of Community Supports – Prior D/C Attempts and Why Not Successful:

IX. Contact list (Provide Name/Telephone of Applicable Contacts):

Health Care Proxy: No Yes

Health Care Agent/Guardian: _____

Phone: _____ Page: _____

Emergency Contact: _____

Phone: _____ Page: _____

Representative Payee: _____

Phone: _____ Page: _____

Case Manager: _____

Phone: _____ Page: _____

Psychiatrist: _____

Phone: _____ Page: _____

Residential Services: _____

Phone: _____ Page: _____

Primary Care Physician: _____

Phone: _____ Page: _____

X. Other: _____

PHYSICIAN'S STATEMENT

I have reviewed the clinical criteria for referring patients to DMH for continuing care inpatient services and believe this patient requires this level of continuing care treatment. If the patient is accepted for transfer, the transfer will comply with M.G.L. c. 123, § 3.

_____, M.D. Date: _____

Signature of Treating Physician

DID YOU REMEMBER TO?

- ATTACHED ALL REQUIRED FORMS FROM CONTINUING CARE REFERRAL CHECKLIST FORWARD ANY OTHER RECORDS FROM YOUR AGENCY THAT WOULD ASSIST THE APPLICANT?
- HAVE THE APPLICANT SIGN THE NOTIFICATION OF TRANSFER (MGL 123.S.3) AND HAS SUPERINTENDENT/HEAD OF DEPARTMENT SIGNED THE NOTIFICATION OF TRANSFER (cannot be the attending psychiatrist).
- IS PATIENT AUTHORIZED FOR DMH SERVICES AND, IF NOT, HAS APPLICATION BEEN FILED WITH DMH?