

LIPOS PRIVATE BED / PHP – RECEIVING FORM

Today's Date: _____

EHR # _____

Client Information

1. First Name: _____ 2. MI _____ 3. Last Name _____

4. Social Security Number ____ / ____ / ____

5. Admitting Hospital / Partial Hospitalization Program:

Dominion INOVA – Loudoun INOVA – Mt. Vernon INOVA – Fairfax Prince William

Virginia Hospital Center Snowden Poplar Springs Spotsylvania Out of Area _____

6. Authorizing CSB:

Alexandria Arlington Fairfax Loudoun Prince William

This is to certify that inpatient psychiatric or Partial Hospitalization services have been rendered to the individual listed above by the hospital / program identified above, under the terms and conditions of the LIPOS acute bed purchase agreement.

7. Dates of Approved Service: From ____ / ____ / ____ To ____ / ____ / ____ 7a. PHP Total Days ____

8. Clinical Status at Discharge / Transfer: _____

9. Ongoing Follow Up / Treatment Arrangements: _____

10. PHP Program Only: At time of discharge client received or did not receive discharge instructions.
Discharge planner received or did not receive a copy of the client's discharge instructions.

11. Hospital Only:

Level of Care at time of Discharge / Transfer: Level 1 (Acute Stabilization) Level 2 (Intensive Care)

Level I – Acute Stabilization

- High acuity, **low** complexity
- Substance-induced symptomatology
- Situational crises resulting from psychosocial stressors
- Situational difficulties resulting from Axis II symptomatology
- Stopped taking medications or in need of medication adjustment (with history of good response to medication)

Level 2 – Intensive Care

- High acuity, **high** complexity
- Current lack of willingness or ability to participate in treatment
- Long-term, persistent or recurrent psychiatric difficulties
- Complex discharge issues (i.e., homelessness, lack of social support)
- May include medical co-morbidity

12. If Transfer, Check transfer criteria met:

(1) Confirmed DSM-IV diagnosis, **and**

(2) There is a substantial likelihood of harm to self, and/or

There is a substantial likelihood of harm to other(s), and/or

Demonstrates persistent lack of capacity to protect self from harm or to provide for basic human needs, and/or

Has a condition that requires intensive monitoring of newly prescribed drugs with a high rate of complications or adverse reactions, and/or

Has a condition that requires intensive monitoring and intervention for toxic effects from therapeutic psychotropic medication and short term community stabilization is not deemed to be appropriate, **and**

(3) Alternatives to admission have been investigated and there is no less restrictive alternative to admission.

13. Project Discharge / Transfer Approval

CSB Representative Name: _____ Date: ____ / ____ / ____