MEDICAL CLEARANCE FOR ADMISSION TO NVMHI

Individual's Name: _____Transfer Endorsed by: _____

Date: _____Time: _____ CSB: _____

Individual's Legal Status ☐ TDO ☐ CMA ☐ INVOLUNTARY ☐ VOLUNTARY

Date of Legal Status: _____ Date of Expiration of Legal Status: _____

Primary Contact at Transferring Hospital _____

Phone Number: _____ Fax Number:_____

Minimum Required Information:

☐ CSB Pre-Screen (w/ **ALL** CURRENT meds)
☐ Urine Drug Screen
☐ Vital Signs (within last 2 hours)
☐ Blood Alcohol Level
☐ Medical History
☐ CIWA Score
☐ Urine Pregnancy Test
☐ Physical/Neurological Exam

Additional Required Information (when requested by NVMHI Primary Care/>60 years):

☐ Comprehensive Metabolic Panel
☐ Urinalysis
☐ CBC
☐ Medication Blood Levels When Applicable (eg. Dilantin, Lithium, Depakote, Tegretol)
☐ Acetaminophen/Salicylate Levels (if suspected overdose)

If pregnant and in second or third trimester: OB ultrasound ☐

If new onset mental status changes or psychosis: Head CT ☐

Please note that additional tests may be requested depending on results to assure that the individual can be cared for at NVMHI.

Required information to comply with Joint Commission standard for Continuity of Care and Handoff Communication between healthcare providers.

☐ MD Admission Psychiatric Assessment
☐ MD & Nursing Progress Notes from last 2 weeks, **all the way up to the date of transfer**
☐ Medication Reconciliation Record **on the day of, or the day before transfer**

INSTRUCTIONS:

1. Please check off boxes for information being sent in the completed packet.
2. **PLEASE FAX ALL INFORMATION AT ONE TIME.** Incomplete information cannot be processed for medical clearance, thus delaying the process.

Fax to: **Admissions Office (703) 207-7150**

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NVMHI Admissions/PCP Staff Use

Individual's Name: _____
Date/Time Initial Fax/Information Received: _____

All Information Requested Received: Yes ☐ No ☐ Date/Time: _____

Missing Information: _____
_____
_____
_____

Facility/CSB Notified of Missing information:

Date: _____Time _____ Name of Person Notified: _____

MEDICAL CLEARANCE INITIATED:

Name of PCP: _____ Date: _____ Time:_____

Individual is medically cleared: Yes ☐ No ☐ Date: _____ Time:_____

Doc to Doc: Yes ☐ No ☐ Date/Time: _____

ED Doc Name: _____ Phone Number: _____

COMMENTS:

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Staff Printed Name and Signature **Date/Time**