PLAINS AREA Mental Health Center
Helping People Cope with Everyday Living

SIOUXLAND MENTAL HEALTH CENTER

seasons

PH: 712-662-8055
FX: 712-662-8054
crisishome@pamhc.org

PH: 712-560-7996
FX: 712-560-9202
crisiscenter@siouxlandmentalhealth.com

PH: 712-262-2922
FX: 712-264-9388
alexsplace@seasonscenter.org

Please check which program(s) is the individual being referred to:

☐ **23-Hour Observation and Holding**

- ☐ Siouxland Mental Health Crisis Center

☐ **Subacute**

- ☐ Siouxland Mental Health Crisis Center

☐ **Crisis Stabilization Residential Services - Adult**

- ☐ Turning Point – Plains Area Mental Health Center
- ☐ Siouxland Mental Health Crisis Center
- ☐ Alex's Place - Seasons Center for Behavioral Health

☐ **Crisis Stabilization Community- Based Services – All Ages**

- ☐ Plains Area Mental Health Center
- ☐ Siouxland Mental Health Crisis Center
- ☐ Seasons Center for Behavioral Health

Dependent upon the location, at least one of the following criteria may prohibit the individual from admittance:

- Acute medical condition – Note: individual may be monitored and screened for later acceptance of admission.
- Inability to complete activities of daily living by self (toileting, showering, dressing, grooming, etc.)
- Sex offender
- High risk behavior of violence
- Over the legal alcohol limit; may admit after a lab test showing under the legal limit.
- Currently detoxing due to alcohol

Referral Information

Name: _____ Preferred name: _____

DOB: _____ SSN#:_____ PH: _____

Address: _____County: _____

Legal Guardian or Power of Attorney? Yes __ No ___ If Yes, Who: _____

Emergency Contact Name & PH: _____

MCO/Medicaid #: _____ Other Insurance: _____

Sex: _____ Sexual Orientation: _____Gender Identity: _____

Preferred Pronouns:_____ Race: _____ Military Y/N: _____ Marital Status: _____

Religious preference and needs (food, routines, etc.):

_____

Check all the following behaviors that apply:

____ Manic Behavior	____ Threatening Others	____ Paranoia
____ Borderline Traits	____ Auditory Hallucination	____ Aggressive Behavior
____ Visual Hallucinations	____ Depression	____ Anxiety
____ Self-Harm	____ Isolated or Withdrawn	____ Sexual Problems
____ Current and/or History of Eating Disorder		____ Current and/or History of Pica

Please describe impairments that are occurring due to mental health symptoms:_____

_____

_____

_____

_____

History

Mental Health Illness: Yes_____ No ____ If yes, List Diagnosis: _____

Currently receiving outpatient psychiatric treatment?

Yes ____ No ____ If yes, Name of Provider & Agency: _____

Currently have a Case Manager, Integrated Health Home worker, or DHS case worker?

Yes ____ No ____ If yes, Name of Worker & Location: _____

Please attach a list all prescribed and over-the-counter medication the individual is currently taking. Include recently stopped medications.

Name of Current Pharmacy: _____

SUBSTANCE USE SCREENING: *Please ask the individual the following.*

The last time they used in the past month	Not at all	1-3 days	3 days or more
Any type of alcohol (beer, liquor, wine)			
Marijuana			
Methamphetamines			
Cocaine			
Heroine			
Ecstasy			
Inhalants (fluids, gasoline, lighters, paint)			
Prescription drug abuse (Xanax, OxyCotin, Vicodin, Codeine)			
OTC medication abuse			

Discharge Planning:

List any pertinent medical information, discharge planning, support system, follow-up information:_____

_____

_____

_____

Provide the following list of clinical information:

- History & Physical or most recent Primary Care Physician Note, if applicable
- Psychiatric Evaluation and supporting documentation, if applicable

The purpose of this referral has been explained to me and I voluntarily choose to participate.

Individual Signature: _____ Date: _____

I have reviewed the material, and it is my professional opinion that the individual is appropriate for a lower level of care than inpatient behavioral health.

Referring Provider & Agency Signature: _____ Date: _____

Print Name:_____