



PLEASE COMPLETE AND FAX ALL REQUESTED REFERRAL DATA TO 229-433-8780			
GENERAL INFORMATION			
Name:		DOB (m/d/y):	<input type="checkbox"/> Male <input type="checkbox"/> Female
Facility (Name)			Postal code:
Address:		Phone:	
Referral date:	Referring person:	Primary Insurance:	Secondary Insurance:
Primary Care Provider:		Phone:	Fax:
Aware of referral? Yes No			
Family/Significant Other:		Phone:	Power of Attorney:
Patient agrees with referral? Yes No Caregiver agrees with referral? Yes No		Advance Directives: (DNR, POLST, POA— Healthcare and/or Financial):	
Reason for referral (check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Mood Disorder — severe, recent exacerbation <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Psychosis/delusional/hallucinations <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> Physical aggression in response to care <input type="checkbox"/> Physical aggression spontaneous <input type="checkbox"/> Sexual inappropriate/aggression <input type="checkbox"/> Physical agitation (exit-seeking, wandering) <input type="checkbox"/> Verbal aggression <input type="checkbox"/> Verbal agitation <input type="checkbox"/> Other 			



Please provide brief narrative of recent events prompting this referral:

REFERRAL CHECKLIST

Please provide copies of the following:

- Previous psychiatric consultation documentation
- Relevant diagnostics
- Most recent Medication Administration Record (PRN medications and new orders)
- Recent PCP documentation
- Recent hospitalization data
- Power of Attorney/Advanced Directive documentation
- Nursing notes for at least the past 72 hours
- Facility demographic face sheet/ Insurance cards/Photo ID
- Immunization record (GRITS)

FUNCTIONAL STATUS

Communication: Are there any barriers (language, aphasias)? Language(s) spoken?	Sleep patterns: <ul style="list-style-type: none"> <input type="checkbox"/> Sleeps all/most of the night without medication <input type="checkbox"/> Sleeps all/most of the night with medication <input type="checkbox"/> Disrupted 	Precautions: <ul style="list-style-type: none"> <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> Hep B <input type="checkbox"/> Hep C <input type="checkbox"/> TB
Safety: <ul style="list-style-type: none"> <input type="checkbox"/> Wandering risk <input type="checkbox"/> Determined elopement risk <input type="checkbox"/> Mistreatment/abuse/neglect suspected 	Bladder management: <ul style="list-style-type: none"> <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent 	Bowel management: <ul style="list-style-type: none"> <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent

CURRENT ACTIVITIES OF DAILY LIVING

Bathing: <input type="checkbox"/> Indep <input type="checkbox"/> Supervision <input type="checkbox"/> 1 p assist <input type="checkbox"/> Dependent <input type="checkbox"/> Reluctant <input type="checkbox"/> Refuses <input type="checkbox"/> Cueing
Dressing: <input type="checkbox"/> Indep <input type="checkbox"/> Supervision <input type="checkbox"/> 1 p Assist <input type="checkbox"/> Dependent <input type="checkbox"/> Cueing
Feeding: <input type="checkbox"/> Indep <input type="checkbox"/> Supervision <input type="checkbox"/> 1 p Assist <input type="checkbox"/> Dependent <input type="checkbox"/> Difficulty swallowing
Toileting: <input type="checkbox"/> Indep <input type="checkbox"/> Supervision <input type="checkbox"/> 1 p Assist <input type="checkbox"/> Dependent
Med Admin: <input type="checkbox"/> Indep <input type="checkbox"/> Supervision <input type="checkbox"/> Bubble-pack <input type="checkbox"/> Refuses <input type="checkbox"/> Cueing
Restraint use: <input type="checkbox"/> Physical type <input type="checkbox"/> Chemical type:
Mobility: <input type="checkbox"/> Indep <input type="checkbox"/> Supervision <input type="checkbox"/> 1 p Assist <input type="checkbox"/> 2P Assist <input type="checkbox"/> Lift <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker
Cognitive Impairment: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Referral Agency: _____ Staff Signature: _____ Date: _____



Disclosure:

SGMC Dogwood Senior Health is a secured 12 bed unit, located inside SGMC Berrien Campus in Nashville, Georgia. We specialize in the behavioral health care of adults 55 years of age or older.

*** Exclusionary Criteria includes:

- Complicated medical conditions that preclude active participation
- Dialysis
- Communicable disease that would place other patients or staff at risk
- Repeated admission without evidence of improvement or change

If it is determined that our facility is appropriate for your referral based on the accompanying information, we will begin the admission process. We appreciate your cooperation while addressing all areas of the referral checklist--your knowledge is the first step in creating a successful treatment plan.

Once your referral is received, our team will conduct a thorough review for admission appropriateness. If the prescreening demonstrates 'psychiatric necessity' for admission, the next step is our medical clearance. All patients must be medically cleared through the ER located at SGMC Berrien Campus, unless transferring from another ER or inpatient hospital setting.

Additionally, please be aware that the demand for services fluctuates and immediate bed availability is not always possible. If that is the case at the time of your request, we can place your referral on an admission waiting list and work to have the patient admitted as quickly as possible (usually within a couple of days), or advise for alternative treatment options. Moreover, it may be determined at the time of the medical clearance that the patient has an acute medical issue which precludes behavioral hospitalization—if indicated, medical treatment will be implemented at SGMC Berrien Campus ER/inpatient medical unit or transferred to a higher level of care if medically necessary.

We, at SGMC Dogwood Senior Health Center, are here to meet your needs and those of your patients, so please do not hesitate to contact our staff directly with any questions or concerns at 229-433-8680. We truly value all of our referral sources and understand the magnitude of this request. Lastly, if the safety of the patient or others is jeopardized, immediate transfer to your local emergency department should occur.