Forensic Long-term Structural Residential Facility Preadmission Referral

In order to be considered a complete referral to the LTSR, and thus to be placed on the waiting list, the LTSR Preadmission Referral Form must be completed. All remaining documentation must be submitted for review prior to scheduling for admission.

Last Name: _____ First: _____ Middle: _____

JR, Etc.: _____ Alias: _____ Date of Birth: _____

Address: _____

_____

Sexual Orientation: _____ Gender Identity: _____ SSN: _____

Race: _____ Height: _____ Weight: _____ Hair: _____ Eyes: _____

Veteran: Yes ☐ No ☐ Education level: _____ Marital Status: _____

Primary Language: _____ Religion: _____ Occupation: _____

Income: Yes ☐ No ☐ Income Source: _____ Amount: _____

Medical Assistance: Yes / No If yes, plan and ID# _____

Medicaid: Yes / No If yes, plan and ID# _____

Group # Bin # PCN #

Other Insurance (ex. VA) _____ Plan and ID# _____

Court Case Number: _____ Date of Court Order: _____

Charges: _____

Incarceration Date: _____ Sentenced: Yes ☐ No ☐

Judge: _____ Phone: _____

Probation/Parole Officer: _____ Phone: _____

Defense Attorney: _____ Phone: _____

Boundary Spanner: _____ Phone: _____

Other: _____ Phone: _____

Commitment Status: ☐ 201 (Voluntary) ☐ 304 (Involuntary) ☐ 305 (Involuntary)

Date signed by Judge _____ Date signed by Judge _____

Revised J. Tyler 3/10/21, 3/5/21; Reviewed/Revised A.Chew 11/20/2020; J. Tyler 4/29/2024; J. Tyler 2/25/2025, 3/25/25

Psychiatric Background/Needs

Date of most recent psych eval: _____

Psychiatric Diagnosis(es) *(Please attach additional pages if necessary)*	
1.	
2.	
3.	
4.	
5.	

Prior Psychiatric History: *(Please attach additional pages if necessary)*

Facility/Programs/Outpatient	Dates	Outcome

High Risk Behaviors/Concerns

☐ Suicide Attempt(s); Date(s); Method(s) (use additional sheet as necessary): _____

☐ AWOL	☐ Self-Mutilative	☐ Homicidal
☐ Anorexic	☐ Self-Abusive	☐ History of Fire Setting
☐ Polydipsia	☐ Assaultive/Destructive	☐ Sexually Aberrant Behavior
☐ PICA	☐ Uncontrolled Seizure Disorder	

☐ Other (Please be specific):

Additional Needs/Concerns:

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Medical Background/Needs

Medical Diagnosis(es) – *Please enter all known conditions (attach additional sheet if necessary)*	
1.	
2.	
3.	
4.	
5.	

Current Medications *(attach additional medications on additional sheet)*

Doctor: _____ Phone: _____

Pharmacy used: _____ Location: _____

Medication	Dose	Frequency	Start Date	Takes Meds (Y/N)

Past Medications *(attach additional medications on additional sheet)*

Medication	Dose	Reason Stopped/Side Effects	Comments

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Immunizations (Include PPD): Please attach documentation

Drug Allergies *(Specific reaction)***:** _____

Food Allergies *(Specific reaction)***:** _____

Environmental Allergies: _____

Special Diet: _____

Any current/acute/chronic infectious disease (including COVID): ☐Yes ☐No

If yes, explain: _____

Physical Problems *(including injury(ies); chronic pain; sensory limitation; or others as noted)***:** _____

_____

Ambulation: ☐Unaided ☐Cane ☐Crutches ☐Walker ☐Wheelchair ☐Prosthesis – Specify

_____

Additional Medical/Physical Needs: _____

_____

Drug, alcohol, and nicotine history

Name	First used	Amount Used	How long	Route Taken	Last day of usage	Withdrawals (if yes, explain)

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Drug, alcohol, and nicotine treatment history: *(Please attach additional pages if necessary)*

Facility/Programs/Outpatient	Dates	Outcome

Additional Substance Use Needs: _____

_____

Social Needs/Concerns

Legal:	
Educational:	
Housing:	
Transportation:	
Natural Supports:	
Social Skills:	
Financial:	
Independent Living:	
Cultural:	
PFA/No Contact Orders:	

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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The following documentation is required:

1. General Legal History
2. Court Order(s)
3. Copies of Assessments (less than 6 months old):
    a. Psychiatric
    b. Medical
    c. List of current medications
    d. Competency Evaluation and recommendations
4. Copies of Progress notes and Physician's orders for at least the last three weeks
5. Certificate of Need if under age 22 or above 65
6. County Administrator Approval for admission
7. Physician Certification Form (less than 30 days old)

The following documentation can be provided:

1. Sentencing Sheet
2. Copies of Assessments:
    a. Nursing
    b. Psychological Testing
    c. Psycho-social
    d. Other disciplines involved in patient's care
3. Copies of reports:
    a. Consultations
    b. Laboratory reports and/or other medical studies performed including
        i. Chest x-rays; EKG; EEG; HIV; Hepatitis; TB; CBC; SMAC; WBC; PPD
    c. Medication related to blood levels
4. Copy of current treatment plan

_____ _____

Printed name of person completing form/Title Phone Number

_____ _____

Signature of person completing form Date

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