Telecare Corporation
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# Tranquil Springs Crisis Residential Treatment

# Referral Checklist

**Hello! Thank you for your referral to Tranquil Springs CRT. Below is a checklist to ensure the referral process is efficient and prompt.**

Client must meet the following criteria for admission:

- Age 18-59 {60+ have additional criteria to be discussed during referral process)
- Experiencing a crisis due to mental health or co-occurring substance use conditions OR requiring further recovery from a recent MH acute status
- Referred by Riverside University Health Systems or their contracted CBOs/Providers
- Not actively detoxing (will need medical clearance)

The following documents are required and are referred to as the CRT Referral Packet:

- ☐ RUHS CRT Referral Form
- ☐ County Face Sheet (ELMR)
- ☐ Medi-Cal Eligibility Screenshot
- ☐ Most recent Psychiatric Evaluation and Progress Notes
- ☐ Medication/Labs documentation
- ☐ Medical Information Sheet
- ☐ Drug Screen (UDS/Pregnancy Results)
- ☐ Physician's Report for Community Care Facilities (LIC602)
- ☐ Pre-placement Appraisal Form (LIC603)
- ☐ Functional Capability Assessment (LIC9172)
- ☐ Conservatorship documents and written admission approval if applicable

Please ensure all information requested on the forms is completed. It will facilitate an expeditious admission. The information is needed for clinical or billing purposes. Please fax all documents to 760-670-2730.

Thank you!

Tranquil Springs CRT
47915 Oasis Street, Unit C
Indio, CA 92201
442-282-4909 Office
760-670-2730 Fax
https://www.telecarecorp.com/tranquil-springs-crt

Riverside University HEALTH SYSTEM Behavioral Health

# CRT REFERRAL FORM


**Telecare Lagos CRT - Riverside**
Phone: (951) 509-8320
Fax: (951) 509-8322

**Telecare Tranquil Springs CRT-Indio**
Phone: 442-282-4909
Fax: 760-670-2730

**Jackson House CRT - Temecula**
Phone: (951) 261-8392
Fax: (951) 261-8395


****NOTE: ALL questions must be answered**

| | | | |
|---|---|---|---|
| **DATE OF REFERRAL:** | **TIME OF REFERRAL:** | | **am pm** |
| **REFERRAL INFORMATION** | | | |
| **Referred by:** | **Direct Telephone #:** | | |
| **Referring Agency/Program:** | **Case Manager:** | | |
| **Case Manager Phone Number:** | **Date of Admission to Referring Agency:** | | |
| **CLIENT INFORMATION** | | | |
| **Name:** | **SSN:** | **D.O.B. :** | **AGE:** |
| **Insurance Type:** | **Insurance Number:** | | |
| **ELIGIBILITY SCREENING** | | | |
| **Does client have a history of violence?** YES NO | | | |
| ***If yes, describe:*** | | | |
| *If yes, last 72 hours of nursing notes must be included with referral form. No client exhibiting violence/aggression within the last 72 hours will be accepted.* | | | |
| **Does client have a history of suicidal ideation/attempts?** YES NO * *Attach Description* | | | |
| **Is client a registered sex offender**? YES NO **Registered sex offenders will not be accepted* | | | |
| **MENTAL HEALTH DIAGNOSIS** (Include DSM V and ICD-10 code and labels) | | | |
| | | | |
| **MEDICAL DIAGNOSIS/ALLERGIES** (ICD-10 codes and labels for Physical Health) | | | |
| | | | |
| **CLINICAL HISTORY** | | | |
| **Reason for referral (Please include precipitating event and current symptoms):** | | | |
| **Is client conserved?** YES NO **Note, if conserved, copy of conservatorship papers must be sent with client* | | | |
| ***If yes:*** Name of Conservator: | Conservator's Phone Number: | | |
| **Does client have substance abuse history?** YES NO ***If yes, answer additional questions below:*** | | | |
| Drugs used (including alcohol): | | | |
| Date of last use: | | | |
| History of DTs, seizures or blackouts? YES NO ***If yes, explain:*** | | | |
| **TB testing:** ***You are required to attach one of the following*** | | | |
| Documentation of negative TB test results or clear chest x-ray within the last 12 months. | | | |
| Documentation of PPD placement within the last 24 hours (to be read by CRT nurse 48-72 hrs. after placement). | | | |
| | | | |

| CURRENT MENTAL STATUS | | | | | |
|---|---|---|---|---|---|
| Alert/Oriented | Normal | Abnormal | Self-Injurious Behavior | Present | Not Present |
| Speech | Normal | Abnormal | Delusions | Present | Not Present |
| Behavior | Normal | Abnormal | Suicidal Ideation | Present | Not Present |
| Thought Process | Normal | Abnormal | Homicidal Ideation | Present | Not Present |

***Explain any observations:***

**Medications & Labs: Psychiatric medications are not required to be eligible for CRT services, but highly recommended.**

- **Most recent labs**
- **Medication history, *if applicable***
- **MAR, *if applicable***
- **Two weeks of medications**
- **Injectable Psychiatric Medication was previously prescribed? YES NO *If yes, complete questions below***
  **Medication: Dosage: Date Last Given: Due:**

**REFERRAL CHECKLIST: ALL of the following documents MUST be received prior to approval**

- Referral Form
- County Face sheet
- Most recent psychiatric evaluation
- Medication/Labs documentation
- Drug screen (UDS/Pregnancy Results)
- Conservator court documents & consent (if applicable)
- Medi-Cal Eligibility Screenshot
- Most recent Psychiatric Evaluation and Progress Notes
- Discharge Summary as soon as available
- Physicians Report and Functional Assessment

**CRT STAFF USE ONLY:** *Date/Time Referral Received*: _____ *Staff Initials*: _____

**UPDATES/NOTES:**

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# MEDICAL INFORMATION

Individual Over 59 years of age? Yes ☐ No ☐

Allergies: Yes ☐ No ☐

*If yes, Explain:*

Diabetes: Yes ☐ No ☐

*Insulin Dependent/Self-administer glucose test & insulin:* Yes ☐ No ☐

Hypertension: Yes Yes ☐ No ☐

Respiratory Condition: Yes ☐ No ☐

Primary Care Provider: Yes ☐ No ☐

*If yes, name and contact:*

Special instructions regarding health:

Other medical concerns:

*If a client requires an Epi-Pen, it must be stated on Med Order with specific Allergy and must accompany client.*

# FUNCTIONAL CAPABILITY ASSESSMENT

**Licensees of Adult Residential and Social Rehabilitation Facilities must obtain the following information prior to placement. The Licensee can obtain this assessment information from the applicant or his/her authorized representative. Adult Day Care Facilities and Adult Day Support Centers may use this form to identify the functional ability of the applicant as required. The licensee must maintain this information in the client's file as a part of the Needs and Services Plan.**

**Note: Residential Care Facilities for the Elderly may use this form to assess the person's functional capabilities as required in Section 87584 of the regulations.**

| CLIENT'S NAME | DATE OF BIRTH | AGE | SEX |
|---|---|---|---|
| | | | ☐ MALE<br>☐ FEMALE |

**Check the box that most appropriately describes clients ability:**

**BATHING:**
- ☐ Does not bathe or shower self.
- ☐ Needs help with bathing or showering.
- ☐ Bathes or showers without help.

**DRESSING:**
- ☐ Does not dress self.
- ☐ Needs help with dressing.
- ☐ Dresses self completely.

**TOILETING:**
- ☐ Not toilet trained.
- ☐ Needs help toileting.
- ☐ Uses toilet by self.

**TRANSFERRING:**
- ☐ Unable to move in and out of a bed or chair.
- ☐ Needs help to transfer.
- ☐ Is able to move in and out of a bed or chair.

**CONTINENCE:**
- ☐ No bowel and/or bladder control.
- ☐ Some bowel and/or bladder control.
- ☐ Use of assistive devices, such as a catheter.
- ☐ Complete bowel and/or bladder control.

**EATING:**
- ☐ Does not feed self.
- ☐ Feeds self with help from another person.
- ☐ Feeds self completely.

**GROOMING:**
- ☐ Does not tend to own personal hygiene.
- ☐ Needs help with personal hygiene tasks.
- ☐ Handles own personal hygiene.

**Check the box that most appropriately describes clients ability:**

**REPOSITIONING:**
- ☐ Unable to reposition.
- ☐ Repositions from side to side.
- ☐ Repositions from front to back and back to front.

**WHEELCHAIR:**
- ☐ Unable to sit without support.
- ☐ Sits without support.
- ☐ Uses wheelchair.
- ☐ Needs help moving wheelchair.
- ☐ Moves wheelchair by self.

**VISION:**
- ☐ Severe vision problem.
- ☐ Mild/moderate vision problem.
- ☑ Wears glasses to correct vision problem.
- ☐ No vision problem.

**HEARING:**
- ☐ Severe hearing loss.
- ☐ Mild/moderate hearing loss.
- ☐ Wears hearing aid(s).
- ☐ No hearing loss.

**COMMUNICATION:**
- ☐ Does not express verbally.
- ☐ Expresses by facial expressions or gestures.
- ☐ Expresses by sounds or movements.
- ☐ Expresses self verbally.

**WALKING:**
- ☐ Does not walk.
- ☐ Walks with support.
- ☐ Uses walker.
- ☐ Walks well alone.

**Describe client's medical history and/or conditions:**

| List prescription medicine: | List non-prescription medicine: |
|---|---|
| | |
| | |
| | |
| | |

**Describe mental and/or emotional status:**

**Able to follow instructions?** ☐ **YES** ☐ **NO** | **Confused/disoriented?** ☐ **YES** ☐ **NO**

**Participates in social activities?** ☐ **YES** ☐ **NO** ☐ **Active** ☐ **Withdrawn**

**Is there a history of behaviors resulting in harm to self or others that require supervision?** ☐ **YES** ☐ **NO**
**If YES, provide date_____ and describe last occurrence:**

**Does he/she have ability to manage own finances and cash resources?** ☐ **YES** ☐ **NO**

**Is there any additional information that would assist the facility in determining client's suitability for admission? If YES, describe:** ☐ **YES** ☐ **NO**

| SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE | DATE COMPLETED |
|---|---|
| SIGNATURE OF LICENSEE OR FACILITY REPRESENTATIVE | DATE COMPLETED |

# PREPLACEMENT APPRAISAL INFORMATION

## Admission - Residential Care Facilities

**NOTE:** *This information may be obtained from the applicant, or his/her authorized representative. (Relatives, social agency, hospital or physician may assist the applicant in completing this form.) This form is not a substitute for the Physician's Report (LIC 602).*

| APPLICANT'S NAME | AGE |
|---|---|
| | |

**HEALTH** (Describe overall health condition including any dietary limitations)

**PHYSICAL DISABILITIES** (Describe any physical limitations including vision, hearing or speech)

**MENTAL CONDITION** (Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn))

**HEALTH HISTORY** (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)

**SOCIAL FACTORS** (Describe likes and dislikes, interests and activities)

**BED STATUS**

| | |
|---|---|
| ☐ OUT OF BED ALL DAY<br>☐ IN BED ALL OR MOST OF THE TIME<br>☐ IN BED PART OF THE TIME | COMMENT: |

**TUBERCULOSIS INFORMATION**

| | | |
|---|---|---|
| ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY?<br>☐ YES ☐ NO | DATE OF TB TEST | ☐ POSITIVE<br>☐ NEGATIVE |
| ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS?<br>☐ YES ☐ NO | ACTION TAKEN (IF POSITIVE) | |

GIVE DETAILS

**AMBULATORY STATUS** (this person is ☐ ambulatory ☐ nonambulatory)

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device. An ambulatory person must be able to do the following:

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane. |
| ☐ | ☐ | Mentally and physically able to follow signals and instructions for evacuation. |
| ☐ | ☐ | Able to use evacuation routes including stairs if necessary. |
| ☐ | ☐ | Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation). |

**FUNCTIONAL CAPABILITIES** (Check all items below)

| YES | NO | | | |
|---|---|---|---|---|
| ☐ | ☐ | Active, requires no personal help of any kind - able to go up and down stairs easily | | |
| ☐ | ☐ | Active, but has difficulty climbing or descending stairs | | |
| ☐ | ☐ | Uses brace or crutch | | |
| ☐ | ☐ | Feeble or slow | | |
| ☐ | ☐ | Uses walker. If Yes, can get in and out unassisted? | ☐ Yes | ☐ No |
| ☐ | ☐ | Uses wheelchair. If Yes, can get in and out unassisted? | ☐ Yes | ☐ No |
| ☐ | ☐ | Requires grab bars in bathroom | | |
| ☐ | ☐ | Other: (Describe) | | |

_____

**SERVICES NEEDED** (Check items and explain)

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Help in transferring in and out of bed and dressing_____ |
| | | _____ |
| ☐ | ☐ | Help with bathing, hair care, personal hygiene _____ |
| ☐ | ☐ | Does client desire and is client capable of doing own personal laundry and other household tasks (specify) _____ |
| ☐ | ☐ | Help with moving about the facility _____ |
| | | _____ |
| ☐ | ☐ | Help with eating (need for adaptive devices or assistance from another person)_____ |
| | | _____ |
| ☐ | ☐ | Special diet/observation of food intake _____ |
| | | _____ |
| ☐ | ☐ | Toileting, including assistance equipment, or assistance of another person_____ |
| ☐ | ☐ | Continence, bowel or bladder control. Are assistive devices such as a catheter required? _____ |
| ☐ | ☐ | Help with medication _____ |
| | | _____ |
| ☐ | ☐ | Needs special observation/night supervision (due to confusion, forgetfulness, wandering) _____ |
| ☐ | ☐ | Help in managing own cash resources _____ |
| ☐ | ☐ | Help in participating in activity programs_____ |
| | | _____ |
| ☐ | ☐ | Special medical attention _____ |
| | | _____ |
| ☐ | ☐ | Assistance in incidental health and medical care _____ |
| | | _____ |
| ☐ | ☐ | Other “Services Needed” not identified above _____ |
| | | _____ |

Is there any additional information which would assist the facility in determining applicant’s suitability for admission? ☐ Yes ☐ No

If Yes, please attach comments on separate sheet.

**To the best of my knowledge; I (the above person) do not need skilled nursing care.**

| SIGNATURE | DATE COMPLETED |
|---|---|
| | |

APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE

| SIGNATURE | DATE COMPLETED |
|---|---|
| | |

| LICENSEE OR DESIGNATED REPRESENTATIVE | DATE COMPLETED |
|---|---|
| | |

# PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

**For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).**

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

## FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: | TELEPHONE:

ADDRESS: NUMBER STREET CITY

LICENSEE'S NAME: | TELEPHONE: | FACILITY LICENSE NUMBER:

## RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME: | TELEPHONE:

ADDRESS: NUMBER STREET CITY | SOCIAL SECURITY NUMBER:

NEXT OF KIN: | PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:

## PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE: | HEIGHT: | SEX: | WEIGHT: | IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ **YES** ☐ **NO**

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ **YES** ☐ **NO** If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ **YES** ☐ **NO** If YES, list below:

TREATMENT/MEDICATION:
B) ☐ **YES** ☐ **NO** If YES, list below:

ALLERGIES
C) ☐ **YES** ☐ **NO** If YES, list below:

TREATMENT/MEDICATION:
D) ☐ **YES** ☐ **NO** If YES, list below:

Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:

☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

**Nonambulatory**: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

**Bedridden**: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

| **I. PHYSICAL HEALTH STATUS:** ☐ **GOOD** ☐ **FAIR** ☐ **POOR** | COMMENTS: | | | |
|---|---|---|---|---|
| | **YES** ***(Check One)*** | **NO** | ASSISTIVE DEVICE | COMMENTS: |
| 1. Auditory impairment | | | | |
| 2. Visual impairment | | | | |
| 3. Wears dentures | | | | |
| 4. Special diet | | | | |
| 5. Substance abuse problem | | | | |
| 6. Bowel impairment | | | | |
| 7. Bladder impairment | | | | |
| 8. Motor impairment | | | | |
| 9. Requires continuous bed care | | | | |

| **II. MENTAL HEALTH STATUS:** ☐ **GOOD** ☐ **FAIR** ☐ **POOR** | COMMENTS: | | | |
|---|---|---|---|---|
| | **NO PROBLEM** | **OCCASIONAL** | **FREQUENT** | IF PROBLEM EXISTS, PROVIDE COMMENT BELOW: |
| 1. Confused | | | | |
| 2. Able to follow instructions | | | | |
| 3. Depressed | | | | |
| 4. Able to communicate | | | | |

| **III. CAPACITY FOR SELF CARE:** ☐ **YES** ☐ **NO** | COMMENTS: | | |
|---|---|---|---|
| | **YES** ***(Check One)*** | **NO** | COMMENTS: |
| 1. Able to care for all personal needs | | | |
| 2. Can administer and store own medications | | | |
| 3. Needs constant medical supervision | | | |
| 4. Currently taking prescribed medications | | | |
| 5. Bathes self | | | |
| 6. Dresses self | | | |
| 7. Feeds self | | | |
| 8. Cares for his/her own toilet needs | | | |
| 9. Able to leave facility unassisted | | | |
| 10. Able to ambulate without assistance | | | |
| 11. Able to manage own cash resources | | | |

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

| CONDITIONS | OVER-THE-COUNTER MEDICATION(S) |
|---|---|
| 1. Headache | |
| 2. Constipation | |
| 3. Diarrhea | |
| 4. Indigestion | |
| 5. Others *(specify condition)* | |
| | |
| | |
| | |

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

| | | |
|---|---|---|
| 1. | 4. | 7. |
| 2. | 5. | 8. |
| 3. | 6. | 9. |

| PHYSICIAN'S NAME AND ADDRESS: | TELEPHONE: | DATE: |
|---|---|---|
| | | |

PHYSICIAN'S SIGNATURE

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION** (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

| SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE | ADDRESS: | DATE: |
|---|---|---|
| | | |