Albertina Kerr Subacute Referral Form

Please complete the form below and submit with the documentation outlined in the "Albertina Kerr Subacute Referral Requirements."

QUESTIONS? Contact the Access Center at 503-408-4705 or AccessCenterInbox@AlbertinaKerr.org

DEMOGRAPHIC INFORMATION:

Complete the table below and **provide a hospital or clinic face sheet** with *current demographic information* from patient's medical record.

Youth Legal Name:	
Youth Preferred Name:	
DOB:	
Insurance Information (include copy of card)**:**	
Current Home Address:	
Hospital or Treatment Program where youth is currently located (if applicable):	
Parent or Guardian Information: (Name, Address, Phone Number(s))	

MENTAL HEALTH ASSESSMENT:

Include a recent **mental health assessment and / or clinical documentation within the past week by a QMHP / LMP**. **Also, please complete the summary table below:**

Current Diagnoses:	

Summarize the current mental health crisis, symptoms, and safety concerns by providing a recent Mental Health Assessment and/or clinical documentation within the past week by a QMHP / LMP. *****Note for referring Clinician***:** Please indicate yes or no for each question below. If youth exhibits any of the behaviors listed below, provide a brief description:	
Self-Harm Behaviors:	
▪ Suicidal ideation/suicide attempts – if recent toxic ingestion is youth physically medically clear?	
▪ Aggressive behaviors (in what environments does aggression	

occur, what does it look like, and towards whom?)	
▪ Sexualized behaviors (what does it look like and towards whom?)	
▪ Auditory/Visual Hallucinations, paranoid behaviors	
▪ Risky behaviors	
▪ Drug/Alcohol use, including type of substances, frequency of use, and date of most recent use	
▪ **ADLs**: Can youth independently complete activities of daily living? If no, please describe limitations.	
History: Provide a brief history of prior mental health treatment	
Recommended Level of Care: ▪ Provide recommendation for subacute level of care, including specific treatment goals desired in a secure setting. ▪ Indicate why subacute is more appropriate vs. increased outpatient supports or acute hospitalization.	

HOSPITAL DOCUMENTATION [Complete this section if youth is coming from an emergency department or hospital]
***Note for referring Clinician**:* Please indicate yes or no for each question below. **Include all supporting medical records with the referral**:

▪ Mental health assessment	
▪ H&P/psychiatric assessment	
▪ All labs and vitals taken	
▪ BMI	

▪ MAR to see which meds were given in the ED	
▪ Nursing notes	
▪ Incident reports	

OTHER MEDICAL INFORMATION:

Please include a brief description & any supporting medical records for all that apply.

Current Medications: A complete list of all medications, dosages, and who prescribes them (including over the counter and supplements) OR a note indicating the child is not on medication.	
Any known hospitalizations in the last 3 months? If so, please list hospital information and date(s) of service.	
Specialized Care:	
▪ **Does youth require specialized care?** If yes, summarize and provide medical documentation. ○ For example, Diabetes, Crohn's Disease, Celiac Disease, Seizures, Eating disorders, Allergies, etc.	
▪ **Concerns with Eating?:** If yes, please describe briefly & include: BMI, documentation of any significant recent weight loss or gain, how many meals per day child eats and what percentage of meals are eaten, or formal diagnosis.	

CARE TEAM & DISCHARGE PLAN:

Clinical Support of Subacute Referral: Provide a statement from the youth's Outpatient Mental Health treatment team/Clinician indicating they are supportive of the Subacute Referral.	
List the youth's team members, including contact information & affiliated organizations:	
▪ All therapists	

▪ PCP	
▪ Psychiatrists/Psychiatric NP	
▪ Caseworkers	
▪ Care coordinators	
▪ Probation officers	
▪ Legal guardians	
▪ DD workers	
▪ Skills trainers	
▪ Specialists	
▪ Other	
Discharge plan: Can the youth return to their living situation upon concluding services from Subacute? If No, outline the plan for living arrangements following Subacute service conclusion.	
DHS: Is there DHS involvement, either historical or current, in the youth or family's life? If Yes, please explain and include contact information for the Youth's current DHS support team.	

SUBMITTING A NEW REFERRAL:

Send all information to the Albertina Kerr Subacute Access Center:
▪ **Via secure email to AccessCenterInbox@AlbertinaKerr.org**
▪ **Via Fax to 503-254-6759**

QUESTIONS? Contact the Albertina Kerr Subacute Access Center at 503-408-4705

Please review the Referral Requirements in the Albertina Kerr Subacute Referral Packet for more information.