Channel Marker

MENTAL HEALTH AND WELLNESS SUPPORT

Residential Crisis Services

Please send referral and additional clinical information to:

8865 Glebe Park Dr, Unit 1 Easton, MD 21601 Fax: (410) 822-6186 Phone: (410) 822-4619

Channel Marker, Inc. requests clinical information from your agency that supports the necessity for services. Please include with the completed referral the following, as available.

Social History/Intake/Evaluation
Psychological and/or Psychiatric Evaluations
Discharge Summaries/Treatment Plans from last placement/hospitalization
Medical Evaluations and Clearance

DEMOGRAPHIC INFORMATION

Name:

Date Of Birth: Age Social Security Number:

Address: Phone number:

Living Arrangement: Private Residence/Parent/Guardian Homeless/Shelter Individual can return: Yes
Institutional Setting Jail/Corrections No
Residential Care Other

If Consumer has a Legal Guardian please list name and address:

Race: White Black or African American
Asian American Indian/Alaskan Native
Nat Hawaiian/Other Pacific Islander Not Available

Birth Gender: Male Female Gender Identity

Marital Status: Single Married Separated Divorced
Widow/Widower

Emergency Contact: Relationship:

Address: Phone Number:

FINANCIAL INFORMATION

Insurance: Medicaid Insurance number:
Medicare

Income: SSI SSDI Employment wages
Other

CLINICAL CRITERIA

Diagnosis ICD10 Code

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Current medications and monitoring orders are required for Residential Crisis Services to monitor medications-Please attach copies of orders.

Medications:

Is the client taking medication as prescribed?

Yes No

TREATMENT AND SERVICE HISTORY

Is individual currently receiving mental health treatment ? Yes No

Prescriber:

Name of Agency: Phone Number:

Number of Psychiatric ER visits or admissions or other crisis episodes in the past 12 months:

Place of occurrence

Reason for occurrence

PSYCHIATRIC SYMPTOMS/RISK BEHAVIORS

Suicidal/ Homicidal Threats or Attempts:
In last 30 days
History of
Unknown
None
Comments:

Self Injurious Behaviors:
In last 30 days
History of
Unknown
None
Comments:

Chronic Anger/ Aggression:
In last 30 days
History of
Unknown
None
Comments:

Trauma Related Symptoms:
In last 30 days
History of
Unknown
None
Comments:

Sexually Inappropriate Behaviors:
In last 30 days
History of
Unknown
None
Comments:

Runaway Behaviors:
In last 30 days
History of
Unknown
None
Comments:

Psychosis/ Hallucinations/ Delusional Thought Content	In last 30 days History of Unknown None	Comments:

CRIMINAL STATUS AND HISTORY

Currently on Probation/Parole/Conditions of Release? Yes No

Is there a valid Court order? Yes No

Is there a history of criminal charges? Yes No

Charges and comments

Access to/Use of Weapons Yes No Unknown

Comments:

Property Damage/Fire Setting:

SUBSTANCE USE AND HISTORY

Describe Current/ History of Use:

Did alcohol or drug use have a significant impact on current crisis?

MEDICAL DIAGNOSIS, CONDITIONS, AND NEEDS

Name of Primary Physician: Primary Physician Unknown:

Medical Conditions (if known):

Dietary Needs: Allergies:

Has the client been medically cleared by a Physician or Hospital ED and deemed appropriate for admission to non medical Residential Crisis Services?

Yes **If yes, attach Medical Clearance**

No

Physician/Facility Issuing Clearance: Date of Evaluation:

FUNCTIONAL IMPAIRMENTS

Marked inability to perform activities of daily living and self care: Yes No

Marked inability to establish/maintain personal support system: Yes No

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AUTHORIZATION AND RELEASE OF INFORMATION

I understand that application for residential crisis services is being made on behalf of me and I agree to this referral for services. I authorize this referring agency to release/exchange information to Channel Marker, Inc. for the purpose of facilitating the referral process. I understand the information exchanged may include diagnosis, evaluations, and progress reports.
In addition, I authorize Channel Marker, Inc. to release/exchange information to Treatment Provider (psychiatrist and therapist) and Emergency Contact for the purpose of facilitating the referral process. I understand I may revoke this consent by written request to Channel Marker, Inc.

Client Signature: Date:

Referring Provider: Credentials: Date:

Signature:

Referring Agency:

Phone Number: Email address: