



Pascal Crisis Services, Inc.

Robert A. Pascal Youth & Family Services, Inc. • Pascal Crisis Stabilization Center
1215 Annapolis Road, Suite 204, Odenton, MD 21113
(410) 975-0067

Adult Crisis Bed Referral Application

Optum Maryland: 800-888-1965 | Provider NPI: 1548618374
Attending Physician: Nicholas Scotto, MD / Melissa Ward, CRNP, FNP-C, PMHNP-BC
Utilization Review: Melissa Brown
Fax Referrals to (410) 923-1329 ATTN: Admissions

Date of Application: _____

Name: _____ Age: _____ DOB: ____/____/____

Sex: Male Female SSN: ____-____-____ DSM-5 Diagnosis: _____

Address: _____ County of Residence: _____

City/State/Zip: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Address: _____ City/State/Zip: _____

Therapist: _____ Phone: _____

Address: _____ City/State/Zip: _____

Referral Source

Self-Referral: (explanation) _____

Hospital EMS Crisis Response Court System Law Enforcement

Other: _____

Name: _____ Title: _____

Organization: _____ Phone: _____

Address: _____ City/State/Zip: _____

Emergency Contact Information

Name: _____ Relationship to Consumer: _____

Address: _____ Phone: _____

City/State/Zip: _____

43 Community Place
Crownsville, MD 21032
(410) 571-4500

1226 Annapolis Road
Odenton, MD 21113
(410) 571-4500

1230 Annapolis Road
Odenton, MD 21113
(410) 874-1236

741 Annapolis Road
Gambrills, MD 21054
(410) 975-0067

Medical Insurance

Medical Assistance: Yes No If Yes, MA#: _____

If no, please list insurance coverage details: _____

Optum Authorization #: _____

Dates of Authorization: _____

Optum Staff Member Name: _____

Eligibility for Crisis Services

(Applicant must meet all criteria to be eligible)

1. Clinical reasons require a temporary separation from living situation
2. Stated a willingness to comply with rules and treatment recommendations
3. Able to care for physical and basic hygiene
4. Must have a psychiatric diagnosis
5. Must be able to self-administer medication

Reasons for Crisis Referral

(Check all that apply)

1. To avert inpatient admission
2. To stabilize the individual to pre-crisis level of functioning
3. To shorten the length of inpatient admission
4. To intervene to reduce the likelihood of crisis recurrence
5. To defuse a current crisis
6. To assist the individual/members to build skills to recognize or prevent crisis situations
7. To evaluate the nature of the crisis
8. To link individuals with services and supports in the community
9. To assist individual and members of their natural support system to develop coping skills for crisis prevention
10. Other: _____

Presenting Problem:

Medication:

Substance Use:

Living Situation:

Any Additional Information:

Consumer's Authorization

I, _____, hereby request Robert A. Pascal Youth &
(Consumer/ Name of Applicant)
Family Services, Inc./Pascal Crisis Stabilization Center and understand and am willing to
participate in Residential Crisis Services. I have read and will comply with the rules. The process
and procedure for discharge has been explained to me.

Consumer Signature

Date

Referral Source Signature with credentials
Must be Masters Level Licensed Clinician or Above

Date

Adult Statement of Medical Clearance

I, _____ certify that _____ is medically cleared.
(Name of healthcare provider) *(Applicant Name)*

In reviewing the record and/or speaking with the applicant, this applicant appears:

- Good physical health
- Requires physical exam
- Requires follow-up with somatic care

If somatic care follow-up is recommended, please provide an explanation:

Please list any somatic medications, if any, including frequency and dosage:

<i>Medication Name</i>	<i>Dosage/Frequency</i>

****ALL SOMATIC AND PSYCHIATRIC MEDICATION AND NECESSARY MEDICAL DEVICES/EQUIPMENT MUST ACCOMPANY THE APPLICANT IN ORDER TO BE ACCEPTED INTO RESIDENTIAL CRISIS SERVICES****

Signature of Healthcare Professional
(Physician, PA, NP, or Psychiatrist)

Date