Robert A. Pascal Youth and Family Services, Inc.
Pascal Crisis Stabilization Center
43 Community Place, Crownsville, MD 21032
Phone: 410-571-4500 | Fax: 410-630-7700

Optum Maryland: 800-888-1965 | Provider NPI: 1548618374
Attending Physician: Nicholas Scotto, MD / Melissa Ward, CRNP, FNP-C, PMHNP-BC
Utilization Review: Melissa Brown

Adult Crisis Bed Referral Application

Date of Application: _____

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

Sex: Male ☐ Female ☐ SSN: _____-____-_____ GAF: _____

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

☐ Hospital ☐ Law Enforcement ☐ EMS ☐ Crisis Response ☐ Other: _____

Name: _____ Title: _____

Organization: _____ Phone: _____

Address: _____ City/State/Zip: _____

Emergency Contact Information

Name: _____ Relationship to Consumer: _____

Address: _____ Phone: _____

City/State/Zip: _____

Medical Insurance

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

Optum Authorization #: _____

Dates of Authorization: _____

Optum Staff Member Name: _____

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Eligibility for Crisis Services

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: _____

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Presenting Problem:

Medication:

Substance Use:

Living Situation:

Any Additional Information:

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Consumer's Authorization

I, _____, hereby request Robert A. Pascal Youth & 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 Date
Must be Masters Level Licensed Clinician or Above

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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:

_____
_____
_____
_____
_____

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 Date
(Physician, PA, NP, or Psychiatrist)