

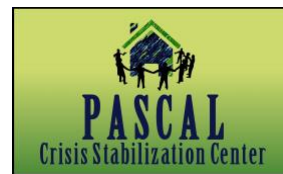


Robert A. Pascal Youth and Family Services, Inc.

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 Scottto, 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: _____

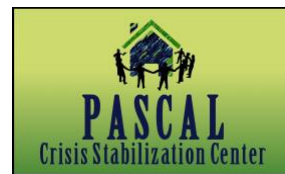


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Eligibility for Crisis Services

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: _____

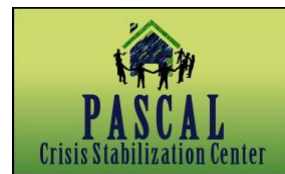


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Presenting Problem:

Medication:

Substance Use:

Living Situation:

Any Additional Information:

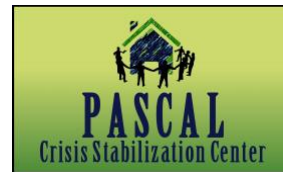


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Consumer's Authorization

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
Must be Masters Level Licensed Clinician or Above

Date

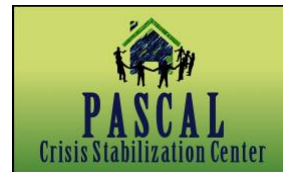


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Adult Statement of Medical Clearance

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
(Physician, PA, NP, or Psychiatrist)

Date