Crisis Residential Referral Form

Healing starts here.

Please complete this form in full and email to **TheLodge@lenapevf.org** with supporting documentation. Referrals must be made with the applicant's knowledge and consent. The Lodge will not accept 302 commitments—all applicants must be voluntary. Please note: The Lodge Crisis Residential reserves the right to direct potential referrals to crisis services for further evaluation and medical clearance as deemed necessary. Please call 267-893-5555 with any questions.

☐ I confirm the applicant is aware of and consents to this referral.

The following are general criteria for admission to The Lodge:

- **The applicant must be eighteen years of age or older.**
- **The applicant requires short-term stabilization due to crisis associated with an apparent serious behavioral health condition, extraordinary life events, and/or psychosocial stressors.**
- **The applicant must be able and willing to participate in safety planning and must be psychiatrically intact enough to benefit from language-based group and individual therapy.**
- **Services provided are voluntary and The Lodge welcomes guests motivated and willing to accept treatment.**
- **The applicant requires more intensive treatment and supervision than what is available in the traditional outpatient settings in order to avoid inpatient hospitalization and/or incarceration.**
- **Prior to the admission, the guest has a stable housing disposition for discharge.**

I. Referring Agency/Individual			
Referral Date	Click or tap to enter a date.	Referral Time	
Referring Agency		Agency Phone	
Agency Contact		Contact Phone	
Agency Email		How did you hear about The Lodge?	

II. Applicant Information			
Applicant Name		Age of Applicant	Choose an item.
Preferred Name		Biological Sex	
DOB		Gender Identity	
Address		SSN	
		Veteran	Choose an item.

Can Applicant return to this address?	Choose an item.	If no or unsure, please provide preliminary disposition plan.	
Living Arrangement	Choose an item.	Marital Status	Choose an item.

Briefly Describe Reason for Referral:

LVF client?	Choose an item.	If yes, currently in treatment?	Choose an item.

If currently in treatment elsewhere, please describe.							
Case Manager		Phone		Therapist		Phone	
Prescriber		Phone		PCP		Phone	
Employer/School				Language			

III. Primary Insurance

Insured's Name		Relationship to applicant	Choose an item.
Insured's Date of Birth		Insured's SSN	
Insurance Company		Insured's ID Number	
Group Number		Insurance Phone Number	
Address		☐ Address Same as Applicant	
		Secondary Insurance?	☐ Yes ☐ No

IV. Mental Health Diagnoses

Diagnosis	DSM5 or ICD-10	

Mental Status Exam

Observations

Appearance	☐ Neat	☐ Disheveled	☐ Inappropriate	☐ Bizarre/Atypical	☐ Other
Speech	☐ No concerns	☐ Tangential	☐ Pressured	☐ Impoverished	☐ Other
Eye Contact	☐ No concerns	☐ Intense	☐ Avoidant	☐ Other	
Motor Activity	☐ No concerns	☐ Restless	☐ Hyperactivity	☐ Slowed	☐ Other
Affect	☐ Full	☐ Expansive	☐ Flat/Blunted	☐ Labile	☐ Other

Mood

☐ Euthymic	☐ Anxious	☐ Positive	☐ Depressed	☐ Euphoric	☐ Irritable	☐ Other

Cognition

Orientation Impairment	☐ None	☐ Place	☐ Object	☐ Time
Memory Impairment	☐ None	☐ Short-Term	☐ Long-Term	☐ Other
Attention	☐ Normal	☐ Distracted	☐ Other	

Perception

Hallucinations	☐ None	☐ Auditory	☐ Visual	☐ Other
Other	☐ None	☐ Derealization	☐ Depersonalization	☐ Ideas of Reference

Thought Content: Delusions

None	☐ Obsessive	☐ Grandiose	☐ Paranoid	☐ Persecutory	☐ Other

Behavior

☐ Cooperative	☐ Guarded	☐ Hyperactive	☐ Suspicious	☐ Paranoid
Stereotyped	☐ Aggressive	☐ Bizarre	☐ Withdrawn	☐ Other
Insight	☐ Intact	☐ Fair	☐ Poor	☐ Other
Judgement	☐ Intact	☐ Fair	☐ Poor	☐ Other

NOTES:

Safety Concerns

Please describe any safety concerns:

Imminent risk to self: Please "X" and explain all that apply.	
☐	Recent suicide attempt or serious self-harm.
☐	Current plan for suicide or serious self-harm.
☐	Current suicidal ideation or urges to self-harm
☐	Command auditory hallucinations for suicide or serious self-harm.
Imminent harm to others: Please "X" and explain all that apply.	
☐	Recent action
☐	Current plan
☐	Command auditory hallucinations for harm to others
☐	History of violent/aggressive behaviors
☐	History of sexually abusive behaviors
☐	Current homicidal ideation
Additional risk factors: Please "X" and explain all that apply.	
☐	Elopement risk
☐	Arson/fire-setting/property damaging behaviors
☐	Treatment and/or medication non-compliance

Treatment History			
Prior Inpatient Treatment?	Choose an item.	Readmission within the past 30 days?	Choose an item.
Age at first admission:		Date of most recent admission:	

Please list past any mental health interventions/services :

Agency/Facility Name	Type of Service	Dates of Service	Frequency of Service (Hours/day)

V. Medical information

Medical Diagnoses, e.g., dementia or acute onset delirium (Names only, ICD-10 not required)

☐ **ADL Concerns? If yes, please describe.**

Current Medications

Please list all current medications (including psychiatric and medical). *If more space is needed, please send medication list separately.*

Drug Name	Daily Dosage	Frequency	Start Date	Diagnosis

Adherence with current medications?	Choose an item.	If no or unsure, please explain	
Any additional pertinent information to support the medical necessity for admission.			

Medical Considerations		
Please "X" and explain all that apply.		
☐	Fall risk	
☐	Durable Medical Equipment (DME)	
☐	Pregnant	
☐	Continuous and/or PRN oxygen use	
☐	Foley catheter	
☐	Cardiac monitoring or extensive cardiac history	
☐	Neuroleptic malignant syndrome	
☐	End-stage terminal illness	
☐	Dialysis/chemotherapy	
☐	Advanced liver disease	
☐	Stage II, IV decubiti/burn care	
☐	Swallowing difficulty/aspiration risk	
☐	Fracture(s)	
☐	Diabetes	
☐	Insulin pumps	
☐	Blood sugars consistently above 300	
☐	New to taking or recently prescribed Coumadin, anticoagulants, or blood thinners	
☐	Exclusive diagnosis of an eating disorder	
☐	Gastric Dysfunction/feeding tube/colostomy	
☐	Incontinence	
☐	Seizure disorder & recent seizure despite med compliance.	
☐	Sleep Apnea (If yes, using CPAP? BIPAP)	
☐	HIV/AIDS (related meds need to be brought)	
☐	Respiratory Conditions (COPD, emphysema, asthma, tuberculosis)	
☐	Hearing/Visual Impairment	
☐	Intellectual Disability/Autism	
☐	Head/Brain Injuries	

Infection Protection	
Please "X" and explain all that apply.	
☐	Does the applicant have a communicable disease (including COVID-19, Influenza, C. Diff, etc.) requiring isolation?
☐	Any symptoms of an infectious communicable disease or COVID-19 such as fever over 100.4, dry cough, fatigue, headache, loss of smell, nasal congestion, sore throat, coughing up sputum, shortness of breath, pain in joints or muscles?
☐	Has the applicant been in close contact with someone diagnosed with a communicable disease over the past two weeks?
☐	Does the applicant have any open wounds, rashes, abscesses or sutures?
☐	Is the applicant taking now or have they taken within the last seven days an antibiotic?
☐	History of MRSA?
Notes	

VI. Substance Use History

	Drug Name	Frequency	Amount	Route	1st Use	Last Use
Alcohol						
Marijuana						
PCP						
MDMA						
Benzodiazepines						
Inhalants						
Amphetamines						
Methamphetamine						
Barbiturates						
Buprenorphine						
Methadone						
Morphine						
Fentanyl						
Heroin						
Cocaine						
OXY						
OTC Meds						
Other						
Overdose? Date? Substance?						
Recent UDS Results:						

VII. Legal (if yes, please explain.)

☐	Current legal charges	
☐	Pending court date(s)	
☐	Currently on probation/parole	
☐	Past legal issues	
☐	Current/History of domestic violence or sexual violence	

VIII. Financial Responsibility & Liability Determination

Lenape Valley Foundation is required by Pennsylvania Title 55, Chapter 4305 to determine financial liability for individuals receiving community behavioral health services, including crisis residential care at The Lodge.

Insurance coverage will be verified prior to admission**. If the applicant does not have active health insurance**, they may be eligible for funding through Bucks County. Financial help is based on monthly household income, household members, no health insurance, Bucks County residence.

Please complete and forward the enclosed Monthly Liability Determination Application to be considered for this funding. Once requested information is received by us, we can determine your level of financial assistance through Bucks County. You will receive a letter from us confirming that amount.

eSignature (Type Name)		Date	

Signature of Referring Body

I affirm all information is a true and accurate description of the above individual.

eSignature (Type Name)		Date	