PeaceHealth

# ADAPT+ Program Referral Form

Pt Name:
DOB:
MRN:
CSN:

To apply for our program, please feel free to call us directly at **360-696-5300**

Providers can refer to us by faxing this form to: **360-729-3372.** ***Please note below exclusionary criteria for referrals.***

If appropriate for ADAPT program, send **ONLY:** •Intake •Most Recent Assessment •Discharge Summary •Med List

**REFERRING STAFF:** ____________________ Date/Time of Referral: ____________________

Referrer's Contact: ____________________ Scheduled Date/Time of Intake: ____________________

**PATIENT INFORMATION**

Legal Name/MRN: ____________________ Phone: ____________ DOB: ____________

Preferred Name: ____________________ Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them/Their ☐ ____________

Email: ____________________ Device: ____________________

Attending in WA State: ☐Yes ☐No Address: ____________________

MH Provider(s) *Therapist/Prescriber* ____________________

Stressors: ____________________

____________________

Drug/Alcohol Use or hx: ☐Yes ☐No ____________________

Hx violent/criminal Behavior: ☐Yes ☐No ____________ Mental Health Dx/ICD-10: ____________________

Suicidal Thoughts: ☐Yes ☐No Plan: ☐Yes ☐No Safe with Self: ☐Yes ☐No Self Harm: ☐Yes ☐No ____________

Current Symptoms:

☐ Depression ☐ Anxiety ☐ Hopeless

☐ Irritable/Anger ☐ Helpless ☐ Guarded

☐ Anhedonia ☐ Isolation ☐ Mania/Hypomania

☐ Sleep_______ ☐ ADL's_______ ☐ AH/VH _______

☐ Delusions/Paranoia/Fears____________________

Recent Exposure to: ☐ Bedbugs ☐ Lice ☐ C-Diff

☐ Covid-19 ☐ Scabies ☐ Other: _________

Current Medications:

____________________

____________________

____________________

____________________

____________________

Insurance Information: ☐ Medicaid ☐Commercial

Medicaid Pic #: ____________________

Name of Insurance: ____________________

Policy #: ____________________

Group #: ____________________

Insurance Phone #: ____________________

Name & DOB of Insured: ____________________

Social Security #: ____________________

Barriers to Attendance (Child care, transportation, work, etc.) ____________________

Medical Conditions: ____________________

Legal Guardian: ☐Yes ☐No ____________________ Referral entered into Care Connect (Internal Only): ☐

## *Possible Exclusionary Criteria for ADAPT Program*

- Primary Diagnosis of Substance Abuse
- Dementia/Alzheimer's
- Developmental Disability
- Organic Brain Disorder/Traumatic Brain Injury
- Behavior that disrupts the classroom
- Other medical issues that prevent safe treatment in a mental health ambulatory program. (i.e.: unable to toilet, eat, ambulate, or take meds independently)

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