Long Term Care Referral Screening Form: Tip Sheet

The SF/LTC Referral Screening Form is a summary of the clinical information presented in the referral packet meant to demonstrate to the facility why the client would benefit from their program. It is the first impression the facility has of the referred client.

Please be sure the form is correct and legible.

Contact Information: The Contact Name should be the person at the facility who the LTC facility can contact for more information, to arrange admission, or to ask questions. If the contact information changes, fax in the new contact information. Please be sure to include the direct contact information for the Court Investigator if the client is not yet permanently conserved. Referrals should not be made until the client is at least on a T-Con.

Diagnosis: Must be the most recent primary psychiatric diagnosis; it may be different than the diagnosis on the psychiatric History and Physical note.

If the client is being referred for an NBU Patch, include both the traumatic brain injury (TBI) or neurocognitive impairment (NCI) diagnosis AND the mental health diagnosis that the client had prior to a TBI or NCI.

Current Risk Factors: Should be completed based on the client's current risk while in current facility. Historical risk factors should be documented in "Historical Risk Factors" or "Historical Dangerous Propensities".

Reason for Referral to This Level of Care: Should build the case as to why the client needs this level of care. It should state what has been tried in the past and why it did not work. Every referral should be individualized so that the important or unique qualities of each client stand out. Stating the "Client has been determined to be gravely disabled by the Conservator, and the Court has ordered Locked Placement" does not convey any important or unique qualities of the client and just repeats admission requirements.

Current Treatment: Should give both an overview of the treatment the client is currently receiving, and the client's response to treatment. Details should include current medications, if PRNs required, group attendance and participation. Specific examples give more information than generalizations. For example, "Client continues to have delusions that yellow pills are poison" provides a more accurate picture of the client than "Client is delusional". Comments such as "See chart" do not summarize the treatment and do not provide information that will assist a facility in determining whether or not a client is appropriate for admission.

History of Prior Hospitalizations/MHRC/STP/State Hospital/SNF Treatments: Include dates and prior placements. Responses such as "many" or "lots" have less impact than "Three hospitalizations in the last three months" or giving the specific hospitalization dates in the last year.