

RN TO COMPLETE ALL SECTIONS

Date Rec'd _____ Time Rec'd _____ Patient Name: _____

BHC contact: Spoke to: _____

Chief complaint & precipitating events: (include client's perception of need) and current BX: _____

Is patient intoxicated? Is patient cognitively able to participate in eval? Yes No BAL _____

Any history of medical issues? (i.e. HTN, Diabetes, COPD, Hx sleep apnea, etc.): _____

Is patient on Lithium Yes No Lithium level done Yes No Results _____

Is patient on Warfarin Yes No Labs done Yes No Results _____

Is patient on Depakote Yes No Depakote level done Yes No Results _____

Current vitals: B/P _____ T _____ R _____ P02 _____ Time _____

Current labs: Pending Yes No – results _____ Tox Screen _____

Current Meds: (attached Med Reconciliation form is necessary) _____

Allergies/reaction (medication environment, food): _____

Respiratory system issues: History of infection/TB, if yes: _____

TB screen in the past year? Yes No (POS or NEG) Date read: _____

Does the patient require a Durable Medical Equipment? (i.e.: CPAP, cane walker, etc.) _____

Mobility: Ambulatory Non Ambulatory Fall risk explain: _____

Pain? Yes No (explain/describe): _____

Cardiovascular Issues: Yes No GI/GU issues: Yes No Neurological issues: Yes No

Invasive lines: Yes No Skin issues: Decubitus Yes No stage and location: _____

ER RN Signature _____ **Date** _____

Dr. to Dr. Yes No Names: _____

Physician contacted: Dr. Gill Dr. Robinson Dr. Smith Dr. Zia

Patient, _____, has received a basic physical examination at _____, and has been found to be free of any acute life-threatening illness, or contagious diseases. As of this date, the patient is deemed medically clear to be transported to SJBHC, (a non-medical, acute psychiatric facility).

Patients will not be accepted if they require:

- Chronic dialysis that is provided outside of service area
- IV treatments including control lines or PICC in place
- Stage III or IV pressure ulcers
- Overdoses in which there is a risk of delayed complications
- Respiratory isolation
- Cardiac or respiratory monitoring
- Oxygen dependent*
- NG tube feedings

Recommendations over next 8-12 hours:

Physician Signature _____ **Date** _____

(* Consultation with SJBHC physician required to determine appropriateness for admission)
Fax to: 467-8107
