**Regional Hospital**

**PATH Team Referral Form**

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| **This form must be completed in full.****\*\*\*Please Copy Regional Field Office Transition Coordinator on all referrals.\*\*\***Region 3 Path Teams: CAPNRobin Bledsoe404-815-1811Robin.bledsoe@capn.orgCFIPatrick Jones404-875-0381pljones@communityfriendship.orgGradyDavid Petty404-277-4185dpetty@gmh.eduHope AtlantaDeldrick Wilson404-645-9173dwilson@hopeatlanta.orgSt. Joseph’s Mercy CareKenya Arnold678-843-8952karnold@mercyatlanta.org | PATH Use Only |
| **Date Received:** | **Name:** |
| **Email:** **[ ]** | **Phone:****[ ]** |
| **Interpreter needed****Yes [ ] No [ ]**  |
| **1st scheduled visit:** |
| **Date of discharge:** |
| **Transportation Plan:****Date of Pick-up:****Time:****Location:** | **Placement Plan:** |
| **Check List:**HUD McKinney Disability Verification Form ⬜TB Test Results □RPR Test Results □Homeless Verification/Shelter Referral Letter □Prescription □Does individual have resources to get filled? ⬜ Y or ⬜ N30-day supply of meds □ \_\_\_\_\_\_-day supply of meds □ |

## 1. Hospital Referral Source Information:

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| **Name:** | **Job Title:**  |
| **Telephone:** | **Fax:** |
| **Email:** |

## 2. Individual

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| **Name:**  | **Gender ⬜ M ⬜ F ⬜ T** |
| **Age:** | **Date of Birth** | **Social Security #** |
| **Address** |
| **City** | **State** | **Zip Code** |
| **County** | **Contact Number(s):** |
| **Admission Date:**  |
| **Diagnosis: (may attach copy of information from Avatar—OR—complete below)** |
| **Mental Health Diagnoses:**  | **Substance Abuse Diagnoses:**  | **Medical Diagnoses:**  |
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| **Medication List: (may attach copy of information from Avatar—OR—complete below)** |
| **MH Medicine(s)** | **Substance Abuse Medication(s)** | **Medical Medication(s)** |
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| **Will patient be given 30-day supply of medication(s)? ⬜ Yes ⬜ No**  |
| *“Upon approval of the hospital’s Clinical Director or designee, more than a 5 day supply of medications may be prescribed and dispensed if the Clinical Director concludes that the patient has no reasonable way of being able to obtain medications and remain compliant with treatment with only a five day supply. The maximum allowable amount of take home discharge medications shall not exceed a 30 day supply.”* (DBHDD Policystat: Discharge Medications and Prescriptions Supplied by DBHDD Hospitals, 03-531 <https://gadbhdd.policystat.com/policy/242304/latest/> ) |
| **\*\*\*Please attach the following\*\*\* Must be attached to referral**  |
| * **1010 (request discharge) date (if applicable):**
* **1010 expiration date (if applicable):**
* **HUD McKinney Disability Verification Form**
 | * **TB & RPR test dates & results**
* **Homeless Verification/Shelter Referral Letter**
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## 3. Scheduled MH Appointment Information

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| **Outcome of contact with ACT, CST, ICM, CM Team of record** Please complete the below. Contact should be attempted prior to PATH referral to determine level of PATH assistance required. **Community Provider/ AMH Appointment:**1. **Date provider was contacted by hospital**:
2. **Service contacted** :
3. **Date of appointment**:

Appointments other than open access may be more clinically appropriate and should be sought. CCPs are required to work with hospital staff to achieve this. (See CCP Standard 3 - Transitioning of Individuals in Crisis, 01-203 <https://gadbhdd.policystat.com/policy/1463786/latest/> )*“For referrals from CSUs, state operated or public or private hospitals, the CCP agrees to have a mechanism to receive appointments for the individual to be seen by an appropriately licensed or credentialed professional within seven (7) business days of discharge (or sooner if clinically indicated), and with a licensed physician/psychiatrist to occur within fourteen (14) business days of discharge (or sooner if clinically indicated, particularly for uninsured individuals who cannot get their prescriptions filled).”* |

**4. Additional Referral Notes**

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|  **Include information regarding what alternatives to shelter placement were discussed with the individual prior to PATH referral and or shelter discharge: (May attach completed and signed Request for Shelter Placement Form)** |