pennsylvania
DEPARTMENT OF PUBLIC WELFARE

OUTPATIENT COMPETENCY EVALUATION REFERRAL

PREADMISSION CONTACT FORM:

NAME_____ AKA _____

LAST FIRST MI (MAIDEN)

ADDRESS_____ M/F (Circle)

SS#_____ MARITAL STATUS_____ RELIGION_____

DATE OF

BIRTH _____AGE____OCCUPATION_____VETERAN_____BRANCH_____

PRIMARY LANGUAGE IF OTHER THAN ENGLISH_____

COUNTY OF RESIDENCE_____COMMITTING COUNTY_____

COMMITMENT TYPE (Please circle): 302 303 304 305 COMMITMENT DATE_____

TYPE OF CHARGES:_____

DATE OF ARREST_____ ANTICIPATED COURT DATE_____

JUDGE_____ PHONE #_____

REFERRAL AGENCY_____

Office of Mental Health and Substance Abuse Services I Bureau of Community and Hospital Operations
P.O. Box 2675 I Harrisburg, Pennsylvania 17105 I Phone: 717.783.8335 Fax: 717.787.2866

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

SENDING FACILITY_____PHYSICIAN_____

CALLER_____PHONE#_____

COMMUNITY CASE MANAGER (ICM, CTT, etc.)_____

PHONE# (W)_____CELL_____

PSYCHIATRIC/MEDICAL DIAGNOSIS(ES) – Please enter all known conditions

AXIS I	AXIS II	AXIS III	AXIS IV	AXIS V

HIGH RISK BEHAVIOR: (Past/Present)

_____Suicide Attempt(s); Date(s); Method(s)_____

_____AWOL History
_____Anorexic
_____Polydipsia
_____PICA
_____Self-Mutilative
_____Self-Abusive
_____Assaultive/Destructive
_____Uncontrolled Seizure Disorder
_____Homicidal
_____History of Fire Setting
_____Sexually Aberrant Behavior

Other (please be specific)_____

_____

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

CURRENT MEDICATIONS: (Psychiatric and non-Psychiatric)

Name of Medication	Dosage	Takes Meds Yes/No	Start Date	Over the Counter and Herbal Supplements

MEDICAL DEPARTMENT CONTACT NUMBER:_____

DRUG ALLERGIES (Specify Reaction):

_____

PHYSICAL PROBLEMS (Including recent injury(ies); chronic pain; or otherwise noted:

_____

_____

_____

RECENT PSYCHOLOGICAL TESTS: Y/N_____ WILL SEND: _____

PRIOR HOSPITALIZATIONS: _____

_____

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

DRUG, ALCOHOL AND NICOTINE HISTORY:_____

TREATMENT HISTORY:_____

THE FOLLOWING DOCUMENTATION IS REQUIRED:

1. Affidavit of Probable Cause ☐

2. Copies of Assessments:
   - ☐ Psychiatric
   - ☐ Nursing
   - ☐ Social
   - ☐ Psycho-social
   - ☐ Medical
   - ☐ Competency Evaluation
   - ☐ Psychological testing
   - ☐ Other disciplines involved in patient's care

3. Copies of Reports:
   - ☐ Consultations
   - ☐ Laboratory Reports and/or other medical studies performed including:
   - ☐ Chest X-Ray; EKG; EEG; HIV; Hepatitis; TB; CBC; SMAC; WBC; PPD
   - ☐ Medication related blood levels

4. Copies of Progress Notes and Physician's Orders for at least the last three (3) weeks ☐

5. Copy of current Treatment Plan ☐

SIGNATURE /Printed Name_____DATE_____

Office of Mental Health and Substance Abuse Services I Bureau of Community and Hospital Operations
P.O. Box 2675 I Harrisburg, Pennsylvania 17105 I Phone: 717.783.8335 Fax: 717.787.2866