Connecticut BHP
Supporting Health and Recovery

Albert J. Solnit Center
915 River Road
Middletown, CT 06457
T: 860-704-4015
F: 860-730-8430
Females and males ages 13-17

Inpatient Referral Form

Please Fax to CT BHP at 855-584-2172 Attn: Clinical Department
or
Email to CTBHPReferralSubmit@carelon.com
If youth has commercial insurance please submit this form directly to the facility

Date of Referral _____
Referring Person _____ Referring Facility _____
Provider Address: _____
Phone # _____ Fax # _____
Email: _____
Date of Admission to Hospital: _____

Demographic Information

Child's Name: _____ Gender: _____
Date of Birth: _____ Age: _____ Race: _____ Ethnicity: _____
Current Placement: _____ Admission Date: _____
SSN: _____ Primary Language: _____
Medicaid ID: _____
Address: _____
City/State/Zip Code: _____
Home Phone: _____
Emergency Contact (Other than Primary Caregiver): _____
Emergency Contact Phone #: _____

	Parent 1	**Parent 2**
Name:		
Relationship to Child:		
Ethnicity:		
Languages:		
Address:		
Home Phone:		
Work Phone:		
Cell Phone:		
Email:		

Legal Guardian (If other than listed above) Name: _____

Relationship to Child: _____ Home #: _____ Cell #: _____

Email: _____

DCF Involvement (if any): **Client DCF Status:** ☐ OTC ☐ Committed ☐ Investigation ☐ Protective ☐ In-Home

Person ID: _____

DCF Supervisor: _____ Phone: _____

DCF Program Supervisor: _____ Phone: _____

DCF Social Worker: _____ Phone: _____

Fax: _____

Voluntary Care Management (VCM) Involvement (if any):

Voluntary Care Manager: _____ Phone: _____

Email: _____

Juvenile Court Involvement (if any):

Probation Officer: _____ Phone: _____

Email: _____

Arrest History and Offence (when and why):

Living Situation: (Name/Age/Relationship to youth):

Family History, family psychiatric and substance abuse history, intimate partner violence, current family stressors that may be affecting patient:

Family's role and understanding of treatment:

Family's Strengths:

Child's Strengths:

Religious/Cultural Background:

Restrictions/Special Needs based on religious/cultural background (if any

Current Diagnosis:

Behavioral Diagnoses (*Primary is required)*

Code	**Diagnosis**
Code	Diagnosis
Code	Diagnosis
Code	Diagnosis

Medical Diagnoses (if no diagnosis, indicate "None" or "Unknown")

Code	Diagnosis
Code	Diagnosis

Social Elements Impacting Diagnoses (required – Check all that apply)

☐ None ☐ Educational Problems ☐ Financial problems ☐ Housing problems (not homelessness)
☐ Occupational problems ☐ Other psychosocial and environmental problems _____
☐ Problems with access to healthcare services ☐ Homelessness
☐ Problems related to interaction with legal system/crime ☐ Problems with primary support group
☐ Problems related to social environment ☐ Unknown

Current Medication and Dosages: note If medication is psychotropic or medical

Name of Drug	Dose	Schedule	Prescribing MD	Target Symptoms Behaviors

Past Medication Trials:

Name of Drug	Dose	Schedule	Prescribing MD	Target Symptoms Behaviors

Were any medications discontinued due to adverse reactions? If so, which?

Primary Care Physician: _____ Phone: _____

Allergies:

Medical Issues – Significant medical history, hospitalizations?

Recent Testing/EKG/EEG/CAT scan? If yes, when? Any abnormalities?

Identify any potential risk factors that may interact with medications:

Any medical conditions that might impact during use of restraint:

Check all that apply:

☐ Birth Complications ☐ Head Trauma ☐ GI Disease ☐ Seizures ☐ Asthma

☐ Cardiac ☐ Thyroid Disease ☐ Diabetes ☐ HIV/AIDS

Date of Last Restraint: _____ **Reason:** _____

Date of Last Seclusion: _____ **Reason:** _____

Date of Last PRN: _____ **Reason:** _____

Has the child experienced any of the following?

	Current	Past	Unknown /NA		Current	Past	Unknown /NA
Aggressive behavior				Homicidal threats			
Anxiety/Panic attacks				Impulsive behavior			
Depression				Juvenile court involvement			
Dissociative Features				Oppositional behavior			
Eating patters/concerns				Run Away			
Fire setting				School Problems			
Hallucinations - Auditory				Self-Injurious behavior			
Hallucinations - Visual				Sexualized behaviors			
History cruelty to animals				Sleep Problems			
				Suicidal attempts			
				Suicidal ideation			

Trauma history/abuse (current/past/unknow/N/A) – if yes, please explain when and by whom:

Has child ever received any of the following services? (if so, please identify where/when)

Psychiatric Hospitalization: ☐ Yes ☐ No ☐ Unknown

	Agency name & date	Yes	No	Unknown
Substance Use Treatment				
In-home Services (IICAPS, MST, MDFT, etc)				
Outpatient Treatment				
PHP/IOP				
Residential Treatment Center				
Psychosexual Evaluation				
Psychological Testing				
Other				

School Performance:

Child's Current Grade Level: _____

Current School/Town:

Schedule Education Classification? ☐ Yes ☐ No IQ Testing Date: _____

IQ Scores: _____

Last PPT: _____

Academic, Behavioral & Social Functioning in School. Note any suspensions:

Does the child require a single room? If yes, state reason:

Previous experience with roommates:

Current service providers and natural supports (Name, Agency, Phone, Services provided and dates)

What is the main treatment need that lead you to request admission to Solnit Hospital?

What is the future vision for this youth (i.e. what is the planned discharge environment for which the youth and family will be prepared)?

What are the contributing factors to the main clinical need? Please consider factors (both strengths and vulnerabilities) from multiple life domains including the individual, family, peer, school and community:

What are the recommended interventions corresponding to the most relevant contributing factors stated above?

Regarding the disposition plan for this child:

- ☐ Reunification (if so, with whom)
- ☐ Therapeutic Foster Care (if so, what is the status?)
- ☐ Residential Treatment (if so, what is the status of the CANS packet?)
- ☐ Group Home (if so, what is the status of the CANS packet?)

Signature/Title of the Referring Person:

Date:

*additional documentation/information may be required prior to approval/decision.