A. F. WHITSITT CENTER
REFERRAL CONTACT FORM

Fax: 855-719-2502

Please complete all six (6) referral pages.

DATE RECEIVED: (WHITSITT USE ONLY) ______________________

IDENTIFICATION SECTION:			Please Print		
CONSUMERS NAME: LAST			FIRST	MIDDLE	
RACE:	AGE:	GENDER IDENTITY	CONSUMER'S HOME PHONE:	DATE:	
ADDRESS:				CITY, STATE, ZIP:	
SOCIAL SECURITY NUMBER:			DATE OF BIRTH	COUNTY OF RESIDENCE:	
EMERGENCY CONTACT			CONTACT NUMBER	ALTERNATIVE NUMBERS	
REFERRING AGENCY:			CONTACT PERSON:	AGENCY PHONE #/EMAIL:	

INSURANCE: PLEASE SUBMIT COPY OF INSURANCE CARD WITH REFERRAL
WHITSITT ONLY ACCEPTS CARE FIRST BC/BS HMO AND MARYLAND MEDICAID

DOES THIS CONSUMER HAVE HEALTH INSURANCE? YES NO

IF YES, COMPANY: ________________________________ Medicaid or Member#__________________________

UNINSURED APPLICANTS:

PROOF OF INCOME IS REQUIRED FOR:
- all uninsured individuals and all Medicare recipients who do not have Medicaid.
- Have they applied for Medicaid and when? ________________________________

If proof of income is not provided at the time of admission, consumers may be charged 100% per day

SUBSTANCE ABUSE HISTORY: Which of the following substances have you used in the past 30 days?

Substance	Amount used per day	How long has pt been using	Date of last use	Substance	Amount used per day	How long has pt been using	Date of last use
Alcohol				Heroin			
Cannabis/Pot				Methadone			
Cocaine				Other Opiates			
Hallucinogens				Sedative			
Other				Stimulants			

DSM-10 Diagnostic Codes for Substance –Use Disorders (Check the appropriate codes)

	Severe Moderate	Mild		Severe Moderate	Mild
Alcohol	F10.20	F10.10	Opioids	F11.20	F11.10
Cannabis	F12.20	F12.10	Sedatives	F13.20	F13.10
Cocaine	F14.20	F14.10	Stimulants	F15.20	F15.10
Hallucinogens	F16.20	F16.10	Tobacco	F17.20	
Other			Other		
Cognitive or behavioral issues?			What is motivating patient?		
How many outpatient tx episodes for SUD?			How many inpatient episodes for SUD?		
Longest recovery time?			How is their housing status? Risky?		

Rev. 08/12/21

LEGAL STATUS:	
PROBATION/PAROLE YES NO COUNTY/OFFICERS CONTACT_______________________________	**WARRANT** YES NO
COURT DATE PENDING YES NO	**COURT DATE** __________________
CHARGES:	
ARRANGEMENTS FOR PENDING COURT DATES SHOULD BE HANDLED PRIOR TO ADMISSION	

PSYCHIATRIC STATUS:		
	Within the past month	**Within the past year**
1. SUICIDAL THOUGHTS/ATTEMPTS	YES NO	YES NO
2. THOUGHTS OF SELF MUTILATION (ACTS)	YES NO	YES NO
3. HOMICIDAL THOUGHTS/ATTEMPTS	YES NO	YES NO
4. HALLUCINATIONS AUDITORY/ VISUAL/ TACTILE	YES NO	YES NO
If the answer is yes to any of the above, please explain with detailed information.		

Is consumer psychiatrically stable to participate in treatment and follow all the rules and regulations of the A. F. Whitsitt Center.	YES NO

PREVIOUS PSYCHIATRIC TREATMENT	WHEN:
PSYCH MEDS TAKEN	WHERE:
1.	DIAGNOSIS:
2.	DIAGNOSIS:
3.	PSYCHIATRIST:

MEDICAL STATUS: Please bring current medications

Is this Consumer currently taking ANY medications? Yes No **Is the Consumer believed to be medically stable?** YES NO

LIST ANY MEDICAL PROBLEMS, RECENT ILLNESSES OR INJURIES:

Current Medications	Dose Frequency	How long on meds	Current Medications	Dose Frequency	How long on Meds
1.			3.		
2.			4.		

LIST ALL ALLERGIES:

DISABILITIES: List any disabilities and special accommodations/equipment needed during their treatment.

PPD SCREENING:

History of +PPD Yes No **If yes, Consumer must have x ray prior to admission.**

DOES THE CONSUMER HAVE AN ADVANCE DIRECTIVE / MARYLAND MOLST FORM YES NO
Please bring copies at admission

FAILURE TO COMPLETE REQUESTED REFERRAL INFORMATION COULD RESULT IN A DELAY OR DENIAL OF ADMISSION.

ASAM ADMISSION CRITERIA

CONSUMERS MUST MEET 2 OR MORE OF THE HIGH ASAM CRITERIA TO BE ELIGIBLE FOR INPATIENT TREATMENT

	LOW	MEDIUM	HIGH
WITHDRAWAL POTENTIAL	**not under the influence; withdrawal potential =Mild/Low**	**recent use withdrawal potential =moderate, requires 24 hour monitoring**	**Potential for or history of severe withdrawal. Presenting with severe withdrawal requiring medical/nursing monitoring History of or current seizure activity**
BIOMEDICAL CONDITIONS	**Medical complications =None-mild/low; not distracting from treatment**	**Medical condition requires monitoring but not intensive treatment**	**History of or identified medical condition that requires 24 hour medical/nursing monitoring and/or intensive treatment**
EMOTIONAL	**Psychiatric and/or behavioral symptoms =none-mild/low**	**Impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADLs;psychiatric and/or behavioral symptoms are interfering with recovery efforts and require a structured 24 hour monitored setting**	**Has active suicidal/homicidal ideations; acutely psychotic/delusional/ labile impacting ability to engage in treatment, inability to attend to ADLs. Psychiatric and/or behavioral symptoms require 24 hour psychiatric care.**
TREATMENT ACCEPTANCE RESISTANCE	**Ready for/accepting the need for treatment; attending/participating. can identify future goals and plans for recovery**	**Ambivalent about treatment; seeking help to avoid consequences and/or please others; variable to poor engagement**	**Lacks awareness of the need for treatment despite severe consequences; engagement in treatment is minimal or refuses Mandated for treatment by workplace, CPS, and/or Court system**
RELAPSE POTENTIAL	**Can recognize onset of signs and triggers; using coping skills**	**Awareness of potential signs and triggers for MH/SA issues but requires close monitoring**	**Continues to use; unable to recognize potential signs and triggers for MH/SA issues despite conseq-uences. Unable to control use without 24 hour structured setting**
SUPPORT/ RECOVERY ENVIRONMENT	**Supporitve environ-ment for MH/SA issues.**	**Moderately supportive environment/resources for MH/SA issues**	**Environment does not support recovery or mental health efforts Resides with an emotionally/ physically abusive individual or active user. Coping skills and recovery requires a 24 hour structured environment setting**

KENT COUNTY
HEALTH DEPARTMENT

WILLIAM WEBB, HEALTH OFFICER
125 S. LYNCHBURG STREET, CHESTERTOWN, MARYLAND 21620 • PHONE: 410-778-1350

Due to COVID-19, the A. F. Whitsitt Center is taking extra precautions for the care of every consumer to include health history review, current health conditions/symptoms and enhanced disinfection procedure in accordance with CDC guidelines for your safety. If you have checked yes to any of the boxes below you may need to be further assessed by medical staff.

Name:

Date: **Phone:**

Yes **No**

Have you traveled outside of the United States in the last 30 days?
If so where ?

Have you had contact or lived with someone who has traveled outside of the United State in the past 30 days?

Have you tested positive or had close contact with someone who has been confirmed with influenza or COVID-19 (Close contact is greater than 15 minutes and less than 6 feet without wearing a mask.)

Are you experiencing any of the following? Please check all that apply:

Cough	Muscle Pain	Chills or shakes
Headache	Difficulty Breathing	New onset of loss of taste and/or smell

Have you had or currently have a fever above 100.4 degrees in the last two weeks?

Do your currently have or have you experienced in the past 30 days mild to severe respiratory illness unrelated to a previous health condition?

Have you used a fever reducing medication within the last 72 hours?

Consumer is aware that he/she must wear a mask when not in their room?

I understand that it is a requirement of admission to the AFWC program to be tested for COVID-19. Refusal of testing will result in me not being admitted.

I understand I will be isolated in a designated area until negative COVID-19 test results are obtained.

I understand that the A.F. Whitsitt Center will be held harmless for any exposure or contraction of the COVID-19 virus.

I understand, should I show symptoms or test COVID-19 positive, I will be issued a 10-14 day isolation order to remain here at the AFWC. Permission to isolate elsewhere will require Health Officer approval.

I understand a face mask, which will be provided upon arrival, will be required at all times and worn properly unless I am in my room alone.

FAILURE TO COMPLETE REQUESTED REFERRAL INFORMATION COULD RESULT IN A DELAY OR DENIAL OF ADMISSION.

I agree that the above information is accurate and complete. Misrepresentation of the information provided on this form may result in denial of admission. In addition I, the undersigned authorize the staff of the referring agency to release/receive health information including psychiatric and substance abuse records, from the medial records of the above named individual to provide ongoing treatment/aftercare at A.F. Whitsitt. I understand that I may revoke this authorization in writing at any time except to the extent the disclosure has already taken place. I acknowledge that the material authorized for release may contain psychiatric, alcohol, drug abuse, or infectious disease information. I understand that health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996, 45 CFR pts. 160 and 164. This entity is released and discharged from any liability and the undersigned will hold the facility harmless for complying with this “Authorization for the release of Confidential Information.” I authorize the disclosure of my health information as described above and that this authorization is voluntary. I have had full opportunity to read and consider the content of this authorization, and I confirm that the contents are consistent with my intent. This consent expires one year from the date of signature.

CONSUMERS SIGNATURE: **DATE:**

Any incomplete, misrepresented or omitted information regarding the consumer's physical and/or behavioral health status may result in denial of admission to our program. If denial of admission occurs the referring person or agency is responsible for providing return transportation, alternate care arrangements, and meal services for the consumer.

REFERRAL COMPLETED BY: **DATE:**

Referral Printed Name: **Referral Title:**

COVID-19 Addendum: Information for Patients, Families, Referral Sources (8/2020)

Once a consumer has been screened for admission and an appointment date and time assigned, please follow these guidelines:

- Cancel or reschedule any appointments/court dates scheduled that will overlap with inpatient treatment.
- Keep your scheduled admission date and time, late arrivals may not be accepted.
- If you arrive prior to your admission time, you will not be permitted to enter the building until your scheduled appointment time.

Permitted Items

- 5 outfits to wear, night time wear, shoes, and weather appropriate outer gear. If clothes are determined to be inappropriate (eg. revealing, skimpy), the consumer will be directed to change clothes. (All clothes will be washed and dried upon admission).
- Reading glasses
- Envelopes and stamps
- Currently prescribed medications. Diabetics are to bring diabetic supplies (monitor, insulin, etc).
- Tobacco products - factory sealed cigarettes only
- Towels and washcloths are suggested.
- Personal hygiene: toothbrush, toothpaste, 1 shampoo, 1 conditioner, 1 soap (no bath salts), 1 deodorant. Make sure the first few ingredients are not alcohol.
- 1 hair dryer, 1 flat iron **or** curling iron
- 1 set of makeup: foundation, blush, mascara, eye shadow, lip stick/gloss, lip balm
- Reading materials - please use discretion

ITEMS PROHIBITED

- Caffeine
- Any electronic devices (including cell phones)
- Lighters, matches and other sources used for tobacco ignition
- Sharp objects, weapons
- Razors or beard trimmers
- Valuables
- Any clothing, reading materials displaying obscene or drug use related language/photos
- Bedding/stuffed animals
- Nail polish and remover
- Perfumes/Colognes
- Groceries