HARBORCREST PATIENT REFERRAL FORM

FAX TO: Admissions Team AT: 360-537-6492 EMAIL: harborcrestintake@ghcares.org

PATIENT:		**M / F**	**DOB:**	**SSN:**
INSURANCE/PO#: (ID#, GROUP#)				**PHONE:**
ADDRESS:				
DRUG OF CHOICE:				

****SUICIDE SCREEING QUESTIONS****

In the past few weeks have you wished you were dead? YES NO
In the past few weeks have you felt that you or your family would be better off if you were dead? YES NO
In the past week have you been having thoughts about killing yourself? YES NO
Have you ever tried to kill yourself? YES NO How? _____
When? _____
Are you having thoughts of killing yourself right now? YES NO

PRIOR TREATMENT ATTEMPTS:		
ALLERGIES:		**PREGNANT: YES NO** **DUE DATE:**
PSYCH ISSUES: (diagnosed only)		**IS PATIENT SCHIZOPHRENIC: YES NO**
MEDICAL ISSUES: (diabetic, sleep apnea, lung, heart, etc.)		
SKIN ISSUES: (MRSA, open sores, etc)		
REQUIRES ASSISTANCE WITH DAILY ACTIVITIES (Showering, toileting, etc)		**IS PATIENT AMBULATORY** (able to get around without help) **YES NO** **USES: Wheelchair Cane Walker**
LEGAL ISSUES:		
PRIMARY/OB DOCTOR:		
MEDICATIONS:		
DOES PATIENT HAVE ACCESS TO NARCAN®	**YES NO**	**PREFERRED PHARMACY:**
COMMENTS:		