Driscoll HEALTH PLAN
A friend of the family

Behavioral Health Inpatient Admission Notification

I. Identifying Information: Medicaid #: Date: / /

Last Name: First Name: Middle Initial:

Date of birth: / / Age: Sex: Date of Admission: / / Time:
Facility name: Provider#: Name of Contact Person
Commitment type: Effective Dates County Judge

Referral source: ( ) Admitting MD ( ) MH professional ( ) DPRS ( ) Other (list):
Name of admitting physician:
IIA. Primary symptom described in "specific observable behavior" that requires acute hospital care: (Include:
Precipitating events leading to admission:

IIB. Other relevant clinical information, including inability to benefit from less restrictive settings:
(Attach additional pages or documents, as necessary)

IIC. Psychiatric medications (include total daily dose)

IID. Present and past drug/alcohol usage:
Name of chemical(s) Current use?

IIE. Past psychiatric treatment.

1. Number of previous inpatient admissions: ( ) Dates of most recent inpatient stay: / / to / /
2. Previous ambulatory/outpatient treatment (provider or facility, frequency)-If none, why:

III. Admitting diagnosis (Axis I):
IV. Additional diagnosis (Axis II):
Diagnosis (Axis III):
Diagnosis (Axis IV)

IV. Functional assessment scores: DSM IV (AXIS V):

V. After care plan:
Provider or facility:
Signature: Date: