Missing information may lead to delays in processing an application

The Commonwealth of Massachusetts
Department of Mental Health

Psychiatrist's Request for Transfer to DMH Facility

I. HOSPITAL INFORMATION:

Referring Hospital: _____

Referring MD: _____

Email: _____ Phone: _____ Page/Cell: _____

Attending MD *(if different from above):* _____

Email: _____ Phone: _____ Page/Cell: _____

Hospital Social Worker: _____

Email: _____ Phone: _____ Page/Cell: _____

II. IDENTIFICATION:

Patient Name: _____ Date: _____

Address: _____
(number and street) (Apt no) (City) (State) (Zip code)

Birth Date: _____ Sex: ___ Race: _____ Pref. Language: _____
MM/DD/YY M/F Does patient speak English? ☐ Yes ☐ No

Education/Professional skills training: _____Employment_____

Has authorization for DMH care services already been determined for this patient? ☐ Yes ☐ No

If "No" has application been filed? ☐ Yes ☐ No*

Please Note: an application for DMH services is **required for referrals of individuals who are not already authorized to receive DMH services. However, a DMH service authorization is not necessary for a referral to be accepted and a transfer to occur.*

DMH Area Tie (if known): _____ DMH Site Tie (if known): _____

DDS Client: ☐No ☐Yes, If Yes: ☐ID ☐ASD Region of tie: _____

III. LEGAL**:

Date of Admission: _____ Legal Status:

- ☐ 3 Day Hospitalization - M.G.L. c. 123, s. 12
- ☐ Conditional Voluntary Admission - M.G.L. c. 123, ss. 10 & 11
- ☐ Civil Commitment-M.G.L. c. 123, ss. 7&8, Exp. Date: _____
- ☐ District Court Rogers-8b ☐ Probate Rogers, Exp Date: _____
- ☐ HCP ☐ Guardianship: ☐ Person ☐ Conservatorship

Other legal issues (active charges, court dates, stay away/209A orders, probation/parole): _____

_____

_____

_____

_____

**** Copies of all legal paperwork should be included with the admissions packet**

IV. HEALTH INSURANCE:

☐ No health coverage

☐ Medicaid/MassHealth Card #: _____ RID #: _____

☐ MassHealth: ☐ MCO _____ ☐ ACO _____ ☐ BHCP _____
(Name of MCO) (Name of ACO) (Name of Agency)

☐ Medicare ☐ Medicare/Medicaid ☐ One Care ☐ SCO

☐ Other Insurance Name of Insurance: _____ Policy #: _____

Name of Policy Holder: _____

V. DIAGNOSES:

Primary Psychiatric Diagnosis: _____

_____

Other Psychiatric Diagnoses: _____

_____

Medical: _____

_____

VI. BRIEF SUMMARY OF HOSPITAL COURSE: (must include treatment course, adherence, medication trials and response, consultations obtained and results – if neurology or neuro/psych testing attach reports).

_____
_____
_____
_____

VII. Medications *(Psychiatric only):*

1. Current Medications:

Name	Dose	Frequency	Side Effects	If Applicable Level/ WBC-ANC/Date Obtained

Medication Adherence? ☐ Good ☐ Needs Encouragement ☐ Poor

Comments Medication Adherence needs encouragement/poor: _____
_____
_____

2. Discontinued Psychiatric Meds during this hospitalization:

Name	Highest Dose	Course Duration	When/Why Discontinued

VIII. SUBSTANCE USE:

Current (up to 3 months prior to assessment or admission)	Past (> 3 months prior to assessment or admissions)
☐ Alcohol ☐ History of DT's ☐ History of Detox. ☐ Marijuana ☐ Opioids ☐ Overdose ☐ Narcan need/use to reverse overdose ☐ Methadone use for maintenance or detox. ☐ Buprenorphine use for maintenance or detox ☐ IM Naltrexone prescribed ☐ Stimulants (Cocaine, Crack, Meth) ☐ Inhalants ☐ Designer Drugs (ecstasy, bath salts, K, etc.) ☐ Misuse of Prescribed Meds Name/Type: _____ ☐ Other: _____	☐ Alcohol ☐ History of DT's ☐ History of Detox. ☐ Marijuana ☐ Opioids ☐ Overdose ☐ Narcan need/use to reverse overdose ☐ Methadone use for maintenance or detox. ☐ Buprenorphine use for maintenance or detox ☐ IM Naltrexone prescribed ☐ Stimulants (Cocaine, Crack, Meth) ☐ Inhalants ☐ Designer Drugs (ecstasy, bath salts, K, etc.) ☐ Misuse of Prescribed Meds Name/Type: _____ ☐ Other: _____

Toxicology screening done: Date _____ Results: _____

IX: SUBSTANCE TREATMENT HISTORY SPECIFICS (include history use of MAT, OTP, medically supervised withdrawal, residential treatment, or details of positive findings noted in section VIII):

_____

_____

_____

_____

X. RISK BEHAVIORS:

Current (up to 3 months PTA) – please include details in section XI	Past (> 3 months PTA)
☐ Self-Injurious ☐ Suicide Attempts ☐ Assaultive ☐ Elopement ☐ Fire Setting ☐ Problematic Sexual Behavior	☐ Self-Injurious ☐ Suicide Attempts ☐ Assaultive ☐ Elopement ☐ Fire Setting ☐ Problematic Sexual Behavior

XI: SIGNIFICANT CLINICAL/MANAGEMENT ISSUES/POSITIVE MSE FINDINGS:

_____

_____

_____

_____

XII. MEDICAL HISTORY:

1. Medical Problems/Treatments:

_____

_____

COVID-19: Prior: _____, If no prior, Currently POS: ☐ NEG: ☐; Test: No ☐ Yes ☐ Date: _____

TB: PPD Date: _____ Result: NEG: ☐ POS: ☐ If positive, treatment given: _____

REFUSED: ☐ Active Symp.: YES: ☐ NO: ☐ CXR Date: _____ Result: NEG: ☐ POS: ☐

Multi Drug Resistant Organisms: YES: ☐ NO: ☐ UNK: ☐

HIV positive: ☐ Yes ☐ No Hep C: ☐ Yes ☐ No, Treated: ☐ Yes ☐ No

Allergies/Sensitivities: _____

Diet Restrictions? ☐ No ☐ Yes(if yes describe): _____

Physical Limitations? ☐ No ☐ Yes(if yes describe): : _____

Need for Adaptive Equipment ☐No☐ Yes(if yes describe): _____

Need for CPAP? ☐No☐ Yes(if yes, settings):_____

History of Head Trauma/LOC ☐ No ☐ Yes, Date/Describe: _____

2. Surgery/Procedures/Diagnostic Testing/Imaging (and dates completed/obtained):_____

_____

_____

3. Medical Medications: *Current Medications*

Name	Dose	Frequency	Side Effects	If Applicable Blood Level/WBC/Date

Medical Medication Adherence? ☐ Good ☐ Needs Encouragement ☐ Poor

XIII. DIVERSION ATTEMPTS AND WHY NOT SUCCESSFUL: _____

_____

_____

_____

XIV. CONTACT LIST *(Provide Name/Telephone of Applicable Contacts)*:

Type	Name	Phone(s)
DMH service prov(s). (ACCS, PACT, etc)		
Emergency Contact		
HCP		
HC agent (guardian)		
Rep Payee		
Community Psychiatrist or Prescriber		
Primary Care provider		
DMH CM (if applic.)		
Primary family contact		

XVI. Other Information relevant to supporting this application:

_____

_____

PHYSICIAN'S STATEMENT

I have reviewed the clinical criteria for referring patients to DMH for continuing care inpatient services and believe this patient requires this level of continuing care treatment. If the patient is accepted for transfer, the transfer will comply with M.G.L. c. 123, § 3. **Please note that a discharge summary draft is also required 24 hours prior to transfer**

_____, M.D. Date: _____

Signature of Treating Physician

DID YOU REMEMBER TO?

- ATTACH ALL REQUIRED FORMS FROM CONTINUING CARE REFERRAL CHECKLIST; FORWARD ANY OTHER RECORDS FROM YOUR AGENCY THAT WOULD ASSIST THE APPLICANT?
- HAS THE APPLICANT SIGNED THE NOTIFICATION OF TRANSFER (MGL 123.S.3), HAS SUPERINTENDENT/HEAD OF DEPARTMENT SIGNED THE NOTIFICATION OF TRANSFER (**cannot be the attending psychiatrist**), AND HAS THE PATIENT WAIVED 6 DAY NOTIFICATION PERIOD (OR NOT).
- IS PATIENT AUTHORIZED FOR DMH SERVICES AND, IF NOT, HAS APPLICATION BEEN FILED WITH DMH?