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| ***DMH Facility Denial of Inpatient Care Reporting Form*** | |
| To be completed by hospital/unit or by population (e.g., adult, geriatric, child, or adolescent) each time there is a denial, except in an instance when there is no open bed, a bed has been promised to an admission, or in the case when multiple requests have been made for the same patient within a single episode, which has already been documented once, (unless the reason for denial of admission has changed).  This assumes that all criteria for admission have been met, including medical clearance and insurance authorization (if applicable). | |
| General data | |
| Date |  |
| Time (or time of denial) |  |
| Patient initials or number with relevant demographics (which may include age and/or gender relevant for the denial) |  |
| Diagnosis (add additional diagnosis as relevant for demonstrating reasons for denial) |  |
| Referral source |  |
| Patient location |  |
| Signature or documentation that denial was approved by Medical Director/ designee (including name of person). |  |
| Reason/comments | |
| Patient clinical presentation/needs are beyond the current capability:  Private room unavailable Lack of necessary staffing  Quiet room unavailable Specialized unit required  Unable to meet medical needs Other (specify)  Violence reported exceeds ability to manage  Sexually acting out protocol indicated – no ability  Gender does not match available bed |  |
| Unit population mix does not allow admission:  Quiet room unavailable  Other (specify) |  |
| Other extraordinary factors that preclude admission (specify) |  |