

National Psychiatric Care and Rehabilitation Services APPLICATION FOR CRISIS RESIDENTIAL

Please send completed application to the preferred facility:

- [] Sacramento Location: Fax: (916)720-0455 Email: Sacramentoadmissions@npcrs.com Phone: (408)568-9834
- [] San Jose Location: Fax: (707) 667-0010 Email: Sanjoseadmissions@npcrs.com Phone: (707)732-8105
- [] Manteca Location: Fax: (209)320-3529 Email: Mantecaadmissions@npcrs.com Phone: (209)456-5805
- [] Vallejo Location: Fax (707)667-0010 Email: Vallejoadmissions@npcrs.com Phone: (707)732-8105
- [] Walnut Creek Location Fax: (925)-891-9248 Email: Walnutcreekadmissions@npcrs.com Phone: (925)478-2994
- [] San Lorenzo Location Fax: (510) 372-0349 Email: Tiana.James@virosa.org Phone: (341)777-5415

REFERRAL SOURCE INFORMATION

Referring Facility:

Completed By:

Phone Number:

Email:

Fax Number:

PATIENT IDENTIFYING INFORMATION

Client's Name (*last, first, MI*)

Insurance/Kaiser Medical Number:

Gender: Male / Female / Other (*please circle one*)

DOB:

Age:

Preferred Language:

Phone Number:

SSN:

Ethnicity:

Address (*street, city, state, zip code*):

ICD 10 CM DIAGNOSIS

Primary Diagnosis:

Secondary Diagnosis:

PATIENT PROVIDERS

Psychiatrist:

Phone Number:

IUS Case Manager authorizing placement:

Phone Number:

PPD

Test Type: PPD/ CXR/ TB (*please circle one*)

Results: POS / NEG (*please circle one*).

Date Placed:

Date Read:

PATIENT INFORMATION

Ambulatory: [] Yes or [] No

Assistive Device Required: [] Yes or [] No

Homeless: [] Yes or [] No

Discharge Plan:

Legal Status: Voluntary / 5150 (*please circle one*)

Co-Pay:

Dietary Restrictions:

Consent to speak to the patient: [] Yes or [] No

PATIENT QUESTIONNAIRE

In the past 2-14 days has the client experienced the following:

Tested + for COVID-19 [] YES or [] No

Shortness of Breath [] Yes or [] No

Cough [] Yes or [] No

If Yes Date ISOLATION BEGAN: _____

Fever greater than 100.0 F [] Yes or [] No

Date ISOLATION ENDED: _____

OTHER DOCUMENTS Please attach the following documents to the application.

Psychiatric Evaluation and Medication List Physical Examination; Relevant progress notes (psychiatrist and/or nurse); COVID-19 results, PPD reading and any other relevant lab results

SIGNATURE

I certify that all the information stated above is true and correct to the best of my knowledge and belief.

Signature:

Date: