MICHIANA
Behavioral Health
the Right Environment for Healing

3 Important steps to take with a pre-approval request:

1. Call Michiana and ask to speak with intake (or a nurse supervisor if/when intake is not available) to inform them that we should expect a fax.

2. Include the preapproval form that is attached to ensure all proper information is conveyed along with any labs that were performed and pt demographic sheet.

3. Two important fax numbers to utilize: 574/936.6833 (Intake) and 574/941.5733 (Unit fax to nurses station) Feel free to fax to both to ensure someone will receive in real time and diligently respond to your request.

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Today's Date: ____________________

Referral Form for Inpatient Hospitalization

Please fax this form, along with a *demographic sheet* and any notes to 574-936-6833

Patient Name: ______________________________________ DOB: ___________________________

Contact # of Patient: _________________________________ Alternate #: ______________________

Name of Parent / Guardian: ____________________________ Contact #: ________________________

Is patient / family aware you are making this referral? ___Yes ___ No Are they present currently ______Yes___No

*Is client currently: ___suicide risk ___assaultive behavior ___sexual acting out ___sexual victimization ___elopement

Reason for Referral (make sure to list most recent behaviors believed to be in need of inpatient & dates of occurrences):

____

____

____

____

____

Current Medications (including dosages, frequency): _____________________________________

____

____

Allergies: ____

Has the pt required restraints or medication in order to calm? _____ Yes _____ No

Has the patient been diagnosed with Autism or Pervasive Developmental D/O (or show signs of)? ______ Yes ___No

Can the patient perform the Activities of Daily Living without assistance? _______ Yes ___ No

Is the patient lower functioning? ______ Yes ___No (If yes, please explain, grade/age level functioning at) ____________

____

Please list any medical diagnoses or physical health problems: ___________________________

____

Provider making referral: ____________________________________ Contact #: ____________________

Name of provider's facility/organization, city: ____