ACUTE CARE REPORT FORM

Children & Adolescents Not Admitted to Licensed Inpatient Acute Care Facilities

**Complete** **one form for each child for whom admission to an inpatient acute care facility was requested but not obtained FOR 8 HOURS. DO NOT COMPLETE THIS FORM IF YOU OBTAINED ADMISSION IN LESS THAN 8 HOURS. See “Instructions - Acute Care Report Form” for additional information.**

I. General Information *Complete all parts of Section I.*

 **Date Request Initiated: / /**

 **Agency Submitting Data:**

**[ ]** CPMT Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIPS Code: \_\_\_\_\_\_\_\_\_\_\_

 [ ]  CSB Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CSB Code: \_\_\_\_\_\_\_\_\_\_\_

 **Contact Person:** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 FAX #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Child Information:** DOB: / / Last 4 digits of child’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_ Gender: [ ] Male [ ] Female

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| **II. Admission Information *Check all facilities licensed by DBHDS to which admission was requested but not obtained.\**** |
| [ ]  Bon Secours Maryview Behavioral Medicine Center Children's Psychiatry [ ]  Carilion Clinic Roanoke Memorial Hospital Roanoke Memorial Hospital [ ]  Centra Health, Inc. VBH-Krise[ ]  CJW Medical Center Child/Ado Inpatient Psychiatry[ ]  Cumberland Hospital, LLC Inpatient Unit[ ]  Dominion Sleepy Hollow Rd |  [ ]  Inova Health Care Services INOVA Fairfax Hospital [ ]  Inova Health Care Services INOVA Mt. Vernon Hospital [ ]  Kempsville Center for Behavioral Health  [ ]  Lewis Gale Medical Center, Center for Behavioral Health [ ]  Mary Washington Hospital, Inc. Inpatient-Adolescent [ ]  Newport News Behavioral Health Center Acute Care Unit [ ]  North Spring Behavioral Healthcare [ ]  Poplar Springs Hospital Poplar Springs-Adolescents [ ]  Riverside Behavioral Health Center  [ ]  VCU Health System, VA Treatment Center for Children   |
| [ ]  Other Acute Care Facility **(Provide Name Here)** : **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  |
| III. Reason(s) Admission Was Not Obtained *Check all that apply.*   |  |
|  [ ] No bed available for day(s) requested |
|  [ ] Bed available, but child not placed - **Check AT LEAST ONE Child-Specific, Funding or Other Issue below.** |
|  **Child-Specific Issues**  |
|  [ ]  Age of child | [ ]  Physical limitations[ ]  Hearing impaired/deaf[ ]  Vision impaired/blind[ ]  Substance abuse[ ]  Child formerly treated in same facility and facility choosing not to approve subsequent admissions[ ]  Facility not accepting child as voluntary admission[ ]  Child not meeting criteria for involuntary admission[ ]  Type of service needed not available (Specify in **Comments** below.) |
|  [ ]  Gender of child [ ]  Aggressive/Violent/Unable to Control [ ]  Fire-setting [ ]  Running away [ ]  Sex offender/Sexually aggressive [ ]  Mental retardation or borderline intellectual functioning  [ ]  Autism or other developmental disability  [ ]  Learning disability  |
|  Funding Issues |
|  [ ]  No insurance coverage [ ]  No means of payment following involuntary  commitment hearing | [ ]  Medicaid not active because of inmate status[ ]  Child’s insurance (Medicaid, FAMIS, CHAMPUS, private, other) not accepted by facility |
|  **Other Issues *Write in any other issues that have not been listed.*** [ ] No source of transportation to acute care facility [ ]  Facility too far from child’s home community [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

IV. Comments

**Send form via encrypted email to: Pam Fisher, DBHDS, at pamela.fisher@dbhds.virginia.gov**