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)** :  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
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| 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**