



# The Trauma Disorders PROGRAM

PART OF THE SHEPPARD PRATT HEALTH SYSTEM

Dear Referring Clinician:

Thank you for your interest in The Trauma Disorders Program at Sheppard Pratt, a nationally and internationally recognized program for the treatment of individuals with trauma-related conditions including dissociative disorders and other complex post-traumatic conditions. Our program utilizes an intensive multi-disciplinary treatment approach through individual therapy, milieu therapy, and process-oriented, experiential, and psycho-educational group therapies.

Our program provides patients with a structured and supportive environment, with a focus on safety and stabilization, so that they are able to step down to other levels of care, both in our continuum and in their home communities. We are primarily an inpatient unit, with limited outpatient services available.

Before completing the referral packet, please read all of the information provided on the next page. It will explain important details and next steps including the referral process and admissions criteria. Or, if you have questions, please call our admissions coordinator at 410-938-5078.

Sincerely,

Richard J. Loewenstein, M.D.

Medical Director, The Trauma Disorders Program

**SHEPPARD PRATT HEALTH SYSTEM**

6501 N. Charles Street

Baltimore, MD 21204-6819



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## REFERRAL PROCESS FOR ADMISSION TO THE TRAUMA DISORDERS PROGRAM'S INPATIENT UNIT:

- A treating clinician (licensed therapist or psychiatrist) must refer a prospective patient through the admissions coordinator for The Trauma Disorders Program's inpatient unit. You can reach the admissions coordinator by calling **410.938.5078**.
- The treating clinician will be asked to complete the following referral packet. The admissions coordinator will then acquire demographic, insurance, and clinical information for the purposes of intake screening. **Several key requirements must be met for a prospective patient to be considered for admission to the program:**
  - Each patient must have a stable outpatient treatment team in place, including an individual therapist and medication prescriber prior to admission. It is expected that the patient will return to this team after discharge.
  - Patients must have stable and safe housing that they can return to upon discharge.
  - We do not accept involuntary patients or those with a legal guardian.
  - Co-occurring conditions such as substance abuse and/or eating disorders must be stabilized prior to admission. Each case is different; however, and all provided clinical information will be reviewed by the treatment team for appropriateness.
  - Each patient must be medically stable.
  - Each patient must meet medical necessity criteria for acute inpatient mental health treatment.
    - **MEDICAL NECESSITY** for inpatient mental health treatment as defined by most insurance providers includes at least one of the following:
      - An imminent risk of harm to self or others, as noted by the presence of active suicidality and/or homicidality
      - An inability to meet one's basic needs and care for one's self outside of a locked-door hospital setting with 24-hour supervision
      - Significant self-injury or uncontrolled risk taking behaviors that involve imminent risk to self or others
- After reviewing all the provided information with the treatment team, the admissions coordinator will inform the referrer whether the patient has been accepted based upon insurance status and clinical appropriateness. The referring clinician should expect to be the primary contact throughout the admissions process.
- Please note that Sheppard Pratt Health System accepts most major insurance plans including Medicare. At present, we are unable to accept patients with Maryland Medicaid as their primary insurance. We may accept other states' Medicaid if willing to make a specific single case agreement with Sheppard Pratt Health System. Insurance benefits will be verified by our financial department prior to admission. Existing benefits do not guarantee individual authorization for treatment. Authorization for inpatient treatment is determined by the insurance company at the time of admission, based upon each company's standard for medical necessity.
- If the unit is full, patients accepted for admission may be placed on a wait list. The admissions coordinator will contact the referring clinician regarding bed availability and an expected admission date.
- If the program's inpatient unit is full and an immediate hospitalization is necessary, arrangements can be made for admission to a general stabilization unit at Sheppard Pratt Health System. A **possible** transfer will then be explored if the prospective patient has already been clinically accepted to the program. Transfer to The Trauma Disorders Program's inpatient unit is **NOT** guaranteed.

**Questions? Please contact the admissions coordinator at 410.938.5078.**



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Please be as detailed as possible.

Date of Referral: \_\_\_\_\_

## PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Does the individual have a legal guardian?  Yes  No

Emergency Contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## REFERRER'S CONTACT INFORMATION

Referrer's Name and Credentials: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Cell Phone or Pager Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

## LIVING ARRANGEMENT

Marital Status: \_\_\_\_\_ Children: \_\_\_\_\_

Lives with: \_\_\_\_\_

Housing Type (i.e. own home, renting, shelter, group home, etc.): \_\_\_\_\_

Will patient have housing after discharge:  Yes  No If so, where? \_\_\_\_\_

## EMPLOYMENT

Employed:  Yes  No If so, where? \_\_\_\_\_

Employment Status (i.e. full time, part time, disability/workers comp, etc.): \_\_\_\_\_

If not employed, since when? \_\_\_\_\_

Previous Employer: \_\_\_\_\_

Disabled:  Yes  No If yes, since when? \_\_\_\_\_

Reason for disability: \_\_\_\_\_

## OUTPATIENT TREATMENT TEAM

Current Outpatient **Therapist** and Phone Number: \_\_\_\_\_

Current Outpatient **Psychiatrist** and Phone Number: \_\_\_\_\_

Current **Primary Care Physician** and Phone Number: \_\_\_\_\_

Will the patient be able to return to this outpatient treatment team? If no, please explain.

\_\_\_\_\_





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## DEMOGRAPHICS

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Race: \_\_\_\_\_

Religion: \_\_\_\_\_

## INSURANCE INFORMATION

**\*\*Please include copies of all insurance cards, front and back\*\***

**\*\*Please note if policy is COBRA or being paid out-of-pocket\*\***

Name of Primary Insurance Company: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Pre-certification Phone Number: \_\_\_\_\_

Benefits Phone Number: \_\_\_\_\_

Name of Secondary Insurance Company (if applicable): \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Pre-certification Phone Number: \_\_\_\_\_

Benefits Phone Number: \_\_\_\_\_

**Complete the following if the policyholder for either policy is not the referred patient.**

Policyholder's Full Name: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

Employer's Name, Address, and Telephone: \_\_\_\_\_

Employment status with company providing coverage (full time, part time, retired, etc.):  
\_\_\_\_\_



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## **CURRENT MEDICATIONS**

Please list the name of each medication, including dosage and frequency, or attach a medication list to this referral packet. Include ALL medically related prescriptions, over-the-counter medications, and herbal supplement/vitamins.

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Has the referred patient participated in any previous medication trials? List names of medication and any significant side effects?

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Has the individual received ECT treatment? If so, please list dates, frequency, and outcome.

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Has the individual received other treatment (e.g. TMS, ketamine infusion, vagal stimulator, etc.)? If so, please list dates, frequency, and outcome.

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The remaining information should only be completed by the referring clinician/treatment provider.

## DIAGNOSTIC IMPRESSION

Psychiatric Diagnosis: \_\_\_\_\_

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V-Codes: \_\_\_\_\_

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Medical Diagnosis: \_\_\_\_\_

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## PSYCHOLOGICAL HISTORY

Is this patient currently hospitalized? \_\_\_\_\_

Approximate number of previous inpatient admissions: \_\_\_\_\_

Location, admission, and discharge dates for hospitalizations **within the last 24 months**: \_\_\_\_\_

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Please attach copies of any discharge summaries for hospitalizations within the last 24 months.



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## CHILDHOOD TRAUMA HISTORY

Please be advised that state to state reporting laws vary and the team may be obligated to report if no such report has been made. Maryland law dictates reporting of childhood abuse regardless of the current age of the identified victim. Please inform of trauma history below.

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To your knowledge, has abuse been reported? \_\_\_\_\_

Is there a family history of mental health issues or substance abuse? \_\_\_\_\_

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## REASONS FOR HOSPITALIZATION (Please attach additional information to the back of packet as needed)

**Acute/Current Stressor:** (Please indicate specific recent events or instances that have led to an increase in symptoms requiring inpatient hospitalization at this time. Please do not list symptoms in this area.)

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**Current Safety Concerns:** (Including suicidal/homicidal ideations, plans, and all self-harming behaviors)

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**PTSD Symptoms:** \_\_\_\_\_

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**Dissociative Disorder/DID Symptoms:** \_\_\_\_\_

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**Other Symptoms:** \_\_\_\_\_

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**Medical Issues:** (If there are active issues, detail current treatment including medications)

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**Allergies:** \_\_\_\_\_

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**Substance Abuse (past and current use):** (Include names of substances, frequency, and amount of use, longest period of sobriety, and any current or past treatments)

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**History of Violence:** (Recent and previous suicide attempts, self-harming behaviors, and/or any deliberate or accidental harmful behaviors towards others)

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**Eating Disorder Symptoms:** (Past and current symptoms including level of restriction, current weight, frequency of binge/purge episodes, and/or use of laxatives or other weight loss pills, as well as any current or past treatments)

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**Legal Issues:** (Including pending court dates, open cases, worker's comp, etc.)

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## INPATIENT TREATMENT GOALS

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