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 and milieu therapy. We also provide 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. 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,

Benjamin Israel, MD
Service Chief, The Trauma Disorders Program

SHEPPARD PRATT
6501 N. Charles Street
Baltimore, MD 21204-6819
REFERRAL PROCESS FOR ADMISSION TO THE TRAUMA DISORDERS PROGRAM’S INPATIENT UNIT:

Admissions Process:

- A treating clinician (licensed therapist or psychiatrist) must refer a prospective patient to The Trauma Disorders Program’s inpatient unit by completing a referral packet. This packet includes demographic, insurance, and clinical information for the purposes of intake screening and is submitted to the admissions coordinator.
- The admissions coordinator can be reached by calling 410.938.5078. Please contact the admissions coordinator prior to completing the referral packet regarding questions related to eligibility criteria and insurance.
- After reviewing all of the provided information with the treatment team, the admissions coordinator will communicate with you about the status of your application and next steps.
- The referring clinician should expect to be the primary contact throughout the admissions process.
- 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.

Admissions Criteria:

- 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.
- Each patient must have stable and safe housing that they can return to upon discharge.
- Each patient must be medically stable.
- Each patient must meet medical necessity criteria for acute inpatient mental health treatment.
- Each patient must be in a safe environment where they are not actively being abused.
- 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. Prospective patients need to have at least a two-week period of abstinence from substance use prior to admission.

MEDICAL NECESSITY for inpatient mental health treatment, as defined by most insurance providers, includes at least one of the following:

1. An imminent risk of harm to self or others, as noted by the presence of active suicidality and/or homicidality.
2. 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.
3. Significant self-injury or uncontrolled risk-taking behaviors that involve imminent risk to self or others.

Insurance/Authorization Information:

- Sheppard Pratt accepts most major insurance plans including Medicare and Maryland Medicaid. At present, we are not contracted with non-Maryland Medicaid.
- 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.
- It is the responsibility of the referring clinician to obtain the insurance pre-certification prior to the patient admitting to the unit. The admissions coordinator will contact the clinician to review this process.

Questions? Please contact the admissions coordinator at 410.938.5078.
Please be as detailed as possible. Please be aware that all sections must be completed in order to process the referral application.

Date of Referral: ____________________

**PATIENT INFORMATION**

Patient's Name: __________________________________________________________

Preferred name to be called: ______________________________________________

Home Address: __________________________________________________________

Phone Number: __________________________________________________________

Does the individual have a legal guardian?  ❑ Yes  ❑ No

Emergency Contact: ________________________________________________________

Phone Number: __________________________________________________________

**DEMOGRAPHICS**

Date of Birth: _____________________________________________________________

Social Security Number: ____________________________________________________

Race: __________  Preferred Pronouns: __________________

Gender Identity: __________  Sex Assigned at Birth: __________________

**REFERRER'S CONTACT INFORMATION**

Referrer's Name and Credentials: _____________________________________________

Office Phone Number: _______________________________________________________

Cell Phone: __________________________________________________________________

Fax Number: __________________________________________________________________

Email Address: __________________________________________________________________

**OUTPATIENT TREATMENT TEAM**

Current Outpatient Therapist: _________________________________________________

Phone Number: __________________ Fax Number: __________________

Current Outpatient Psychiatrist: ______________________________________________

Phone Number: __________________ Fax Number: __________________

Current Primary Care Physician and Phone Number: _____________________________

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

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
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/worker’s comp, etc.): ________________________________
If not employed, since when? ________________________________________________
Previous Employer: ________________________________________________
Disabled: ☐ Yes ☐ No If yes, since when? ________________________________________________

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.): ________________________________________________
CURRENT MEDICATIONS
Please list all medications, including medications for all somatic conditions; or, attach a medication list to this referral packet. Please include dosage and frequency for all medications listed. Include ALL medically related prescriptions, over-the-counter medications, and herbal supplements/vitamins.

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Allergies: _______________________________________________________________________________________

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Has the individual received non-pharmacological treatments such as: ECT treatment, TMS, stellate ganglion block, or a vagal stimulator?

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DIAGNOSTIC IMPRESSION
Psychiatric Diagnoses:

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Medical Diagnoses/Active Medical Problems: ____________________________

________________________________________________________

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________________________________________________________

TREATMENT 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.
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 by an adult. Please inform of trauma history below.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

To your knowledge, has abuse been reported to Child Protective Services? _____________________________________________________________________________

To your knowledge, is the patient currently experiencing abuse? If so, please elaborate. _____________________________________________________________________________

__________________________________________________________________________

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

__________________________________________________________________________

Adult trauma history: _____________________________________________________________________________

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REASONS FOR REFERRAL FOR HOSPITALIZATION
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: Include suicidal/homicidal ideations, plans, and all self-harming behaviors.

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__________________________________________________________________________

__________________________________________________________________________

Inpatient treatment goals
1. _____________________________________________________________________________

2. _____________________________________________________________________________

3. _____________________________________________________________________________
Please identify the most significant PTSD symptoms that your patient is currently experiencing:

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Please identify the most significant dissociative symptoms that your patient is currently experiencing:

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Other Symptoms: ____________________________________________________________

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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. If usage is current, please specify any anticipated withdrawal symptoms upon admission.

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History of Violence: Include 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: Include 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.
Please use this section to provide any additional information that you would like us to take into consideration about this individual or referral.

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X

Licensed Provider’s Signature

________ I understand that I am expected to continue treating the referred patient after discharge.

Initial

Please note: Our email system is NOT encrypted. To maintain privacy, please return by fax to 410.938.5072, attention: The Trauma Disorders Program Admission Coordinator.

Thank you.