Sheppard Pratt

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

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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.

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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.

_____

_____

_____

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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.):

_____

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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.

Allergies: _____

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

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

DIAGNOSTIC IMPRESSION

Psychiatric Diagnoses:

Medical Diagnoses/Active Medical Problems:

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**:

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 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:

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.)**

Current Safety Concerns: Include suicidal/homicidal ideations, plans, and all self-harming behaviors.

Inpatient treatment goals

1.

2.

3.

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

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

Other Symptoms:

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.

History of Violence: Include recent and previous suicide attempts, self-harming behaviors, and/or any deliberate or accidental harmful behaviors towards others.

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.

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

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

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.