Long Term Care Referral Screening Form

Level of Care Requested (Select one. A separate referral form is need for each level of care.)

☐ MHRC/STP ☐ SD County Funded SNF ☐ SNF Patch ☐ NBU Patch ☐ State Hospital ☐ ARF

☐ Community Care Bungalows *Must have a well-documented Developmental Delay or Intellectual Disability and be declined by all IMD/STP programs.

☐ Request for Reconsideration *Fax directly to the facilities, not to Optum. Summarize what improvements have been made since the original referral.

Facility Information

Referring Facility:		Admit Date:
Contact Name:	Phone:	Fax:

Client Information

Client's Name:		Date of Birth:	Age:
Gender: ☐ M ☐ F ☐ O	Race:	Marital Status:	1st Language:	2nd Language:
Special Needs:				

☐ SSI ☐ SSA ☐ SSDI ☐ Other	☐ Medicare # ☐ Medi-Cal # ☐ Regional Center ☐ VA Benefit	TB Screen Date: TB Results: Allergies:	
UDS at Admission	Results:	BAL at Admission	Results:

Conservatorship Information

Conservatorship (**Required**) ☐ Temporary ☐ Permanent ☐ Public ☐ Private	Date Established:
Conservator/Court Investigator:	Telephone #:
Comments on Court Investigation:	
Case Manager:	Telephone #:
Payee:	Telephone #:
If NO Payee, has an application been made for Payee Services?	Date of Application:

Diagnosis Information	
Use DSM/ICD diagnosis and other clinical or medical considerations	
Primary Diagnosis:	ICD Code:
TBI/NCI, DD, Intellectual Disability Diagnosis:	Other Diagnosis (Clinical or Medical):
Risk Factors	
Current Risk Factors:	
Historical Risk Factors:	
Current Dangerous Propensities:	Historical Dangerous Propensities:

Current Risk Factors	**Weak** → **Strong**				
Weak to Strong	1	2	3	4	5
Suicidal Risk	☐	☐	☐	☐	☐
AWOL Risk	☐	☐	☐	☐	☐
Assaultive Risk	☐	☐	☐	☐	☐
Drug/ETOH Risk	☐	☐	☐	☐	☐
Sexual History Risk	☐	☐	☐	☐	☐

Infectious Disease(s):
Referral Information
Reason for Referral to This Level of Care (Why does the client need this level of care?):
Current Treatment (Response to treatment, medication compliance, participation in groups, etc.):
History of Prior Hospitalizations/IMD/State Hospital/SNF Treatments (Include dates):
Living Situation for Past 12 Months:
Legal issues (Note any probation, warrants, or interaction with legal system):
Psychiatrist Information
Treating Psychiatrist Signature:

Printed Name of Psychiatrist:	Phone:

***Please refer to the “Tips for Completing the LTC Referral Screening Form” which can be found on the Optum San Diego Website (https://optumsandiego.com) for more information.