Precourt Healing Center Admission Request

Please include relevant medical and clinical documentation including lab tests and legal paperwork.

Patient Information:

- Full Name:
- Date of Birth: / /
- Gender at birth: ☐ Male ☐ Female ☐ Other ☐ Declined
- Gender Identity: ☐ Male ☐ Female ☐ Other ☐ Declined
- Home Address:
- City: State: Zip Code:
- Mailing Address (*if different*):
- City: State: Zip Code:
- Phone Number: ( ) -
- Email Address:
- Emergency Contact Name:
- Relationship:
- Emergency Contact Phone Number: ( ) -

Guardian Information:

- Parent 1 Full Name:
- Parent 2 Full Name:
- Parent 1: Date of Birth: / / ;
- Parent 2: Date of Birth: / / ;
- Parent 1 Home Address:
- City: State: Zip Code:
- Parent 1 Mailing Address (*if different*):
- City: State: Zip Code:
- Parent 1 Phone Number: ( ) -
- Parent 1 Email Address:
- Parent 2 Home Address:
- City: State: Zip Code:

- Parent 2 Mailing Address (*if different*):
- City: State: Zip Code:
- Parent 2 Phone Number: ( ) **-**
- Parent 2 Email Address:

Patient Insurance Information:

- Name of Primary Insurance Holder/Guarantor:
- Primary Insurance Provider:
- Policy Number:
- Group Number:
- Secondary Insurance Provider (if applicable):
- Policy Number:
- Prior Authorization for Inpatient Psychiatric Stay Needed? Yes No
- Prior Authorization Reference Number #
- Insurance Point of Contact
- Date/Time of Call:

Referral Information:

- Referred by: ☐ Crisis/Co-Mobile Response Agency
- ☐ ED
- Name of Referring Entity:
- Contact Information of Referring Entity:
- Provider completing this form :
- Contact phone number:
- Referral Type: ☐ Voluntary ☐ Involuntary
- Status:
  - ☐ Short Term Certification
  - ☐ Long-Term Certification
  - ☐ M1

*Please attach copies of the legal documents listed above if applicable.

Presenting Concerns:

- Primary Presenting Concern/Medical and Clinical Rationale Inpatient Behavioral Health Level of Care:

- Current behavioral health symptoms, including severity, duration, mental status, and changes or impairments in functioning due to symptoms (Please attach a clinical summary):

- Medical concerns/chronic health issues, including pregnancy and postpartum status

- Current Diagnoses (include Clinical and Medical):

- Recent hospitalizations (BH or Medical)? ☐ Yes ☐ No
  - If yes, where and when?

- Any Assistant Devices? ☐ Yes ☐ No
  - If yes, what and how is it used (CPAP/O2 machine, etc.)?

- History of suicide attempts or self-harm? ☐ Yes ☐ No include detailed information specific to most recent attempt if applicable.
  - If yes, please provide details (include dates):

  - If yes, please provide details (include dates):

- Metabolic Concerns:

- Health-related social needs and risk factors related to social determinants of health

Medical and Psychiatric History:

- Current Diagnoses (if any):

- Current Medications (including dosage):

- Any allergies? ☐ Yes ☐ No
  - If yes, list allergies:

- Any history of substance use? ☐ Yes ☐ No
  - If yes, substances used:

- Any chronic medical conditions? ☐ Yes ☐ No
  - If yes, specify:

- Previous psychiatric hospitalizations? ☐ Yes ☐ No

- If yes, when and where?

Legal and Safety Concerns:

- Current legal issues? ☐ Yes ☐ No
- If yes, explain:

- Any history of violent behavior? ☐ Yes ☐ No
  - If yes, explain (include dates if possible):

Additional Information:

- Any special accommodation needed?
- Any cultural or religious considerations?
- Any additional information you'd like to provide?

Consent and Signature: I certify that the information provided is accurate to the best of my knowledge. I understand that providing false or incomplete information may affect my treatment plan.

Signature: _____ Date: _____

Name: _____ Title: _____