NEW YORK STATE OF OPPORTUNITY. | Elmira Psychiatric Center

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Governor

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Children's Crisis Respite Residence

Crisis Planned Assessment Summary Admission Decision

EPCChildrenCR@omh.ny.gov

Phone: (607) 737-4990 Fax: (607) 737-4880

Contact Information

Child's Name: _____ DOB: _____ Age: _____

Child's Address: _____

City/State/Zip _____ County: _____

School District: _____ School Contact Number (Fax or Phone#): _____

Insurance Information: _____

Parent/Guardian Name: _____ Contact Number: _____

24 Hour Emergency Contact: _____ Contact Number: _____

Referral Source (Name and Title): _____ Referral Agency: _____

Referral Source E-mail: _____ Phone Number: _____

Criteria for Acceptance

[ ] The child has reached his/her 10th birthday but has not reached his/her 18th birthday.
[ ] The child has a designated mental illness diagnosis.
[ ] The child is not currently under the influence of alcohol or drugs.
[ ] The child is considered medically stable for the program (i.e., no evidence of acute illness/disease).
[ ] The child is capable of self-preservation/evacuation of building during an emergency.
[ ] The child is capable to self-administer his/her medications with supervision.
[ ] The child is not an imminent danger to self or others.

Explain any of the above criteria which the child does not meet:

_____

_____

_____

Crisis/Planned Assessment & Admission Summary

Child's Name:

Child Information

Referral Date: 2.

Referral Time: 4.

Anticipated Admission Date: 6.

Anticipated Discharge Date: 8.

Does the child receive Waiver Services? [ ] Yes [ ] No If no, please continue.

If yes, have you exhausted all other respite options in the area? Please explain.

14.

15.

DSM Diagnosis: 17.

Is this a Crisis or a Planned Respite? [ ] Crisis [ ] Planned Respite

Describe the crisis situation or need for planned respite:

19.

20.

21.

Alerts: (Please include all mental health, behavioral, and/or sensory issues that we need to be aware of so we can provide effective support and supervision for the youth.)

23.

24.

25.

Current Medications

Name:	Dose	Route	Frequency	Date/time of last dose

Crisis/Planned Assessment & Admission Summary

Child's Name:

Allergies: 27.

Type of reaction: 29.

Treatment for reaction: 31.

History

History of Psychiatric and Behavioral Concerns:

History of Medical, Trauma, and/or substance abuse concerns:

Treatment

Recommendations for treatment while at the Crisis Respite Residence.

What are the anticipated discharge needs for the child and family?

Please list all agencies and services family receives related to this child's care:

Crisis/Planned Assessment & Admission Summary

Child's Name:

For EPC CCRR use only:

Reviewed by:

Date: Time:

[ ] Accepted [ ] Declined – Reason: