

**Southern Maryland Community Network, Inc.**  
**The Porter House**  
**P.O. Box 998 Prince Frederick, MD 20678**  
**(443) 432-3893 (office) (443) 486-5740 (fax)**

**Referral Application**

Date of Application: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  M  F  Other If other, please explain \_\_\_\_\_

Social Security #: \_\_\_\_\_ Ethnic Group:  African American  Caucasian  Hispanic

Asian/Pacific Island  Native American/Alaska Native  Other \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Marital Status:  Married  Single  Separated  Divorced  Widowed #children \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**REFERRAL SOURCE:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Date Referred: \_\_\_\_\_ Date Crisis Placement Needed: \_\_\_\_\_

**Emergency Contact Person Information:**

Name: \_\_\_\_\_ Relationship to Consumer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**FINANCIAL STATUS:**

Medical Assistance  M.A. # \_\_\_\_\_ Medicare  M.C. # \_\_\_\_\_

SSI  SSDI  TDAP  Food stamps  Open SOAR case

Earned Income  Source: \_\_\_\_\_ Other Benefits  Specify: \_\_\_\_\_

Employer (if applicable): \_\_\_\_\_

**Eligibility for Crisis Stabilization Services:**

1.  Must have a psychiatric diagnosis. DSM V Diagnosis (es): \_\_\_\_\_

Evaluated by: \_\_\_\_\_ on \_\_\_\_\_  
Please provide credentials (Physician or LMHP) Date

- 2.  Due to acute symptomatology related to the individual’s psychiatric condition has impaired ability to function within the individual’s community living situation and is in need of RCS to avoid inpatient psychiatric admission or to shorten the length the length of inpatient stay
- 3.  Requires separation from living situation due to symptoms of mental illness
- 4.  Expects, with staff support, to be able to comply with treatment recommendations,
- 5.  Can and will complete ADL’s independently, with staff support.
- 6.  Must be able to self-administer medications

An individual is NOT eligible if he/she: (a) has a sole diagnosis of substance use, major neurocognitive disorder (ex:dementia, intellectual disability); (b) is in need of immediate involuntary inpatient psychiatric admission; or (c) is medically unstable, as determined under the HEALTH Occupations Article, Annotated Code of Md. A consumer cannot be excluded if he/she is homeless.

**Medical Necessity Criteria**

In need of crisis stabilization placement in order to:

Inpatient Admission Prevention, which provides services to a consumer who, based upon the consumer’s history, is evaluated by a physician or licensed mental health professional, has a mental disorder and without Porter House Residential Crisis, is at risk for inpatient admission or cannot be discharged from an inpatient facility. COMAR 10.63

Inpatient Admission Alternative, which provides services to a consumer who, based on an evaluation by a physician or licensed mental health professional, has a mental disorder, presents a danger to self or others and without Porter House Residential Crisis, would be admitted to or could not be discharged from an inpatient facility. COMAR 10.63

**Presenting Problems:**

Please describe the pertinent precipitants, nature of the current crisis and symptoms noted: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current symptoms are:  Severe  Intense  Moderate

**Mental Health Risk Assessment (check all that apply):**

[ ] Current risk of harm to self, if yes [ ] Ideation only [ ] Intent [ ] Plan and/or [ ] Means

History of suicidal or self-harming behaviors? [ ] Yes [ ] No, if yes please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

[ ] Current risk of harm to others, if yes [ ] Ideation only [ ] Intent [ ] Plan and/or [ ] Means

History of homicidal or assaultive behavior?  Yes  No, if yes please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this person at risk of abuse or victimization?  Yes  No, if yes please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Elopement risk?  Yes  No, if yes please explain: \_\_\_\_\_  
\_\_\_\_\_

**Mental Status:**

General Appearance:

- Well Nourished  Thin  Obese  Casually Dressed  Inappropriate Clothes  Clean
- Well Groomed  Unkempt/Disheveled

Attitude toward Examiner:

- Cooperative  Uncooperative  Guarded  Suspicious  Demanding  Hostile  Impulsive
- Intrusive  Evasive  Negativistic  Manipulative  Poor Boundaries  Threatening Behavior
- Verbally Abusive

Mood:

- Depressed  Dysphoric  Euphoric  Anxious  Irritable  Agitated  Angry  Frustrated
- Sad  Grieving  Reporting no feeling

Affect:

- Appropriate  Inappropriate  Normal  Restricted  Blunted  Flat  Labile  Elated

Thought Process:

- Goal Directed  Looseness of Associations  Tangential  Circumstantial  Flight of ideas
- Word Salad  Perseveration

Thought Content:

- Guilt  Hopeless  Worthless  Helpless  Self Blame  Obsessions  Compulsions
- Agoraphobia  Other Phobia \_\_\_\_\_

Delusions:

- Denies  Paranoid  Grandiose  Derogatory  Somatic  Being Controlled  Bizarre  Fixed, Long Standing, not Interfering with Functioning  Fixed, Interfering with Functioning

Hallucinations:

- Denies  Auditory  Visual  Tactile  Olfactory

Describe content of hallucinations: \_\_\_\_\_  
\_\_\_\_\_

Cognitive Functions:

- Orientation-  Person  Place  Time  Circumstances
- Memory-  Intact  Impaired
- Concentration-  Intact  Impaired
- Estimate of Intelligence  Below  Average  Above Average
- Insight-  Poor  Limited  Fair  Good  Excellent
- Judgment  Poor  Limited  Intact

**Substance Use/Abuse:**

- Nicotine  Alcohol  Marijuana  Amphetamines
- Hallucinogens  Cocaine/Crack  Heroin  Narcotics  Abuse of Prescription Medications  Other \_\_\_\_\_

Please describe history of addictions/ abuse of any of the above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please describe the level of enhanced support required for this person:

- 24 hours on site  24 hours on site awake  24 hours, one-to-one

**Strengths:**

- Insight  Motivated  Relationship with Therapist  Employed  Financial Stability  Educational Achievement  Stable Health  Stable Relationship  Recreational and Social Involvement  Community Agency/Church/Spiritual/School Involvement  Strong Cultural Identification/Attachment
- Other \_\_\_\_\_

**Barriers:**

- Non-adherence  Lack of Social  Chronic Mental Illness  Financial  Chemical Dependence
- Inconsistent Outpatient Care  Other \_\_\_\_\_

**Medical and Psychiatric History**

Current/Past Hospitalizations:

Date	Hospital

Family/Natural Supports Strengths and Needs: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Psychiatric Medications, Frequency and Dosage:

Medication	Frequency	Dosage

Is consumer on any long acting injectable?  Yes  No If yes, when last received and when due next: \_\_\_\_\_  
 \_\_\_\_\_

Depakote/Lithium/ Clozaril blood work? If yes, when is this due next? \_\_\_\_\_

**Physical Health**

Health care status: A.  Good Physical Health B.  Requires a physical exam C.  Requires a follow-up with somatic care

If you chose B or C please explain: \_\_\_\_\_

Current Somatic Medications, Frequency and Dosage:

Medication	Frequency	Dosage

**Consumer must arrive with at least a 10 day supply of medications or prescriptions to cover this time period.**

**Mutually agreed upon Treatment Strategies:**

- Assistance with medication compliance.       Linkage to community resources, including appropriate housing, entitlements/ benefits and behavioral health treatment.
- Encourage to utilize natural supports.       Encourage socialization with peers and staff
- Provide a safe and structured environment       Assist with developing Coping Skills through individual and group interventions.
- Assistance with reality testing       Provide reassurance and encouragement to reduce anxiety fearfulness, anger, etc.
- Confront maladaptive behaviors       Utilize the Crisis Prevention and Response Plan or verbal or written contracts to promote positive behaviors.
- Reminders regarding personal hygiene.
- Other: \_\_\_\_\_

**Please check recommended services**

- Psychiatrist       Crisis Intervention Program       Outpatient Therapy       Partial Hospital
- Psychiatric Rehabilitation       Residential Rehabilitation       Substance Abuse Tx (outpt)       AA/NA
- Other support group \_\_\_\_\_
  
- Internal Medicine Physician       Adult Protective Services       Adult Day Care       Medical Equipment
- Office on Aging       Targeted Case Mgmt.       Spiritual Counseling       ARC
- SSI/SSDI       SOAR       Supported Employment       DSS
- MA Health insurance       Meals on Wheels       Assisted Living       Geriatric Evaluation
- Home Health Services       Bereavement Services       Food Stamps
- Path Program (Charles County residents only)

**Physical Health Needs**

Diet (Please check):

- Normal       Diabetic Diet       Low-fat/Calorie Restricted \_\_\_\_\_ calories

Food Allergies/Other: \_\_\_\_\_

**Consumer's Authorization:**

I hereby request SMCN's Porter House Crisis Stabilization Services and understand and am willing to participate. I have read and will comply with the rules. My signature indicates my consent to services.

\_\_\_\_\_  
Consumer Signature

\_\_\_\_\_  
Date

I attest that this individual is willing to participate in and would benefit from Porter House Crisis Stabilization Services:

\_\_\_\_\_  
Licensed Mental Health Professional

\_\_\_\_\_  
Date

**The Porter House Rules and Regulations**

**Please review with all potential referrals before referring and assure that they sign in agreement with abiding by these prior to sending a referral to us.**

Welcome to the Porter House Crisis Stabilization program. The following list of house procedures will help ensure that your time at the house proceeds smoothly and results in the best possible outcome. Thank you for taking a moment to review these and ask any questions you might have.

**GENERAL**

1. VISITORS: Allowed when person served is adhering to program expectations. 1 hour per week according to staff availability.
2. Belongings will be searched upon admission, at discharge and if there are items missing in the house.
3. Persons served must manage personal hygiene and keep their space clean.
4. Persons served MAY NOT be in one another's room.
5. Persons served are expected to complete chores as requested during their stay.
6. Belongings: Please secure your personal belongings. Staff are not responsible for these items. If you have items of value they may be secured by staff upon your request and signed out as necessary. An inventory of these items will be kept and signed off on by yourself and staff.
7. PHONE: Phone calls may be made and received until 9pm on the house phone unless there is an emergency. Please limit phone calls to 10 minutes. Only long-distance calls pertaining to treatment will be allowed. Personal cell phones will be secured by staff. There are designated times during each day when persons may use these.
8. QUIET HOURS: Persons served are expected to stay in their room from 11pm to 6am Sunday-Thursday and 12am-6am Friday and Saturday.
9. Persons served are expected to be fully and modestly dressed at all times in public areas.
10. Alcohol and illegal drugs are prohibited.
11. DISCHARGE: Any personal items or medications left behind after discharge will be disposed of in 30 days.
12. No personal vehicles permitted at The Porter House.

**FOOD/KITCHEN**

1. HOURS: 6am-9pm, drinks only after 9pm (exceptions approved by staff).
2. MENU: The posted menu, dietician approved, should be followed.

**SERVICES/TREATMENT**

1. MEDICATION MONITORING: All medications will be stored and monitored by staff.
2. MEDICATION MONITORING: Medications without a prescription are prohibited.
3. TRANSPORTATION: Transportation will be provided to Psychiatric, Medical, Substance Abuse and other appointments identified in the treatment plan. Transportation MAY be provided at staff discretion to buy cigarettes, but this is not guaranteed.

**PERSONS SERVED**

1. Persons served shall speak with respect to others AT ALL TIMES.

2. Sexual remarks and foul language is PROHIBITED.
3. Sexual or physical contact with others is not allowed.
4. Respect the privacy of others while they are changing or using the bathroom. KNOCK first.
4. Physical aggression is not allowed.
5. You will maintain the confidentiality of persons served AT ALL TIMES.

**STAFF & STAFF AREAS**

1. Staff areas will be used ONLY to conduct services that require privacy. Persons served may only enter these areas when asked to do so by staff.
2. Staff direct treatment and safety including, but not limited to, directing appointments, room assignments, safety rules, use and behavior expected in vehicles, chores etc.... It is expected that persons served FOLLOW STAFF INSTRUCTIONS for their safety and that of others in the program.

**POSSIBLE GROUNDS FOR IMMEDIATE DISCHARGE**

**Behaviors that may present a danger to self or others are grounds for immediate discharge. These include, but are not limited to, the following:**

1. Leaving The Porter House grounds without staff permission.
2. Use or possession of alcohol or illegal drugs on or off the premises.
3. Possession of weapons or instruments that may be used as weapons.
4. Destruction of property.
5. Theft (on or off Crisis property).
6. Sexual or physical contact.
7. Verbal abuse or threats towards staff or persons served.
8. Aggressive behaviors.

**I have read and understand the above procedures. I understand that these are to protect my safety and that of others in the Porter House. I understand that the program is voluntary, and I may discharge at my request at any time.**

\_\_\_\_\_  
Consumer's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

**This information has been disclosed to you from records protected by federal regulations governing Confidentiality of the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Pts 160 & 164. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by federal regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.**