|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **National Psychiatric Care and Rehabilitation Services**  **APPLICATION FOR CRISIS RESIDENTIAL**  Please send completed application to the preferred facility:  [ ]Sacramento Location: Fax: (916)720-0455 Email: [Katherine.Luna@npcrs.com](mailto:Katherine.Luna@npcrs.com) Phone: (408)568-9834  [ ]San Jose Location: Fax: (408)549-9800 Email [Debra.Marrama@npcrs.com](mailto:Debra.Marrama@npcrs.com) Phone: (707)732-8105  [ ]San Joaquin/Manteca Location: Fax: (209)320-3529 Email: [Dejamarie.Crozier@npcrs.com](mailto:Dejamarie.Crozier@npcrs.com) Phone: (209)456-5805  [ ]Phoenix or Vallejo: Fax (707)667-0010 Email: [Debra.Marrama@npcrs.com](mailto:Debra.Marrama@npcrs.com) Phone: (707)732-8105  [ ]Walnut Creek Fax: 925-891-9248 Email: [Stacia.Fuller@npcrs.com](mailto:Stacia.Fuller@npcrs.com) Phone: (925)478-2994 | | | | | |
| **REFERRAL SOURCE INFORMATION** | | | | | |
| Referring Facility: | | | | | |
| Completed By: | | | | | |
| Phone Number: | Email: | | | | Fax Number: |
| **PATIENT IDENTIFYING INFORMATION** | | | | | |
| Client’s Name *(last, first, MI)*  **Insurance/Kaiser Medical Number:** | | | | | |
| Gender: Male / Female / Other *(please circle one)* | DOB: | | Age: | | Preferred Language: |
| Phone Number: | SSN: | | | | Ethnicity: |
| Address *(street, city, state, zip code)*: | | | | | |
| **ICD 10 CM DIAGNOSIS** | | | | | |
| Primary Diagnosis: | | | | | |
| Secondary Diagnosis: | | | | | |
| **PATIENT PROVIDERS** | | | | | |
| Psychiatrist: | | Phone Number: | | | |
| Case Manager: | | Phone Number: | | | |
| **PPD** | | | | | |
| Test Type: PPD/ CXR/ TB *(please circle one)* | | Results: POS / NEG *(please circle one)*. | | | |
| Date Placed: | | Date Read: | | | |
| **PATIENT INFORMATION** | | | | | |
| |  |  | | --- | --- | | Ambulatory Status: | Assistive Device Required: [ ] Yes or [ ] No | | Homeless: [ ] Yes or [ ] No | Discharge Plan: | | | | | | |
| Legal Status: Voluntary / 5150 *(please circle one)* | | | | | |
| Co-Pay: | | | | | |
| Dietary Restrictions: | | | | | |
| Consent to speak to the patient: [ ] Yes or [ ] No | | | | | |
| |  | | --- | | **PATIENT QUESTIONNAIRE**  In the past 2-14 days has the client experienced the following: | | **OTHER DOCUMENTS Please attach the following documents to the application**   |  |  |  | | --- | --- | --- | | Tested + for COVID-19 [] YES or [ ] No  If Yes Date ISOLATION BEGAN: \_\_\_\_\_\_\_  Date ISOLATION ENDED: \_\_\_\_\_\_\_\_\_\_\_\_ | Shortness of Breath [] Yes or [ ] No  Fever greater than 100.0 F [] Yes or [] No | Cough [ ] Yes or [ ] No | | | | | | | |
| Psychiatric Evaluation and Medication List Physical Examination; Relevant progress notes (psychiatrist and/or nurse); COVID-19 results, PPD reading and any other relevant lab results | | | | | |
| **SIGNATURE** | | | | | |
| I certify that all the information stated above is true and correct to the best of my knowledge and belief. | | | | | |
| Signature: | | | | Date: | |

Information regarding any client is confidential and/or legally privileged. It is intended only for the internal use of National Psychiatric Care and Rehabilitation Services. Any unauthorized review, use, disclosure, or distribution of legally privileged information is prohibited. Revised 6/9/2023

(please circle one)