Driscoll Children's Health Plan
Psychiatric Hospital Inpatient Admission Form

615 N. Upper Broadway, Suite 1050
Corpus Christi, TX 78401

Phone (877) 455-1053
Fax (361) 653-0432

I. Identifying Information: Medicaid #: Date: / /

Last Name: First Name: Middle Initial:

Date of birth: / / Age: Sex: Date of Admission: / / Time:

Facility name: Provider#: Name of Contact Person

Commitment type:________ Effective Dates County Judge
(If applicable)

Referral source: ( ) Admitting MD ( ) MH professional ( ) DPRS ( ) Other (list):

Name of admitting physician:

IIA. Primary symptom described in "specific observable behavior" that requires acute hospital care:
(Include: Precipitating events leading to admission:

IIB. Other relevant clinical information, including inability to benefit from less restrictive settings:
(Attach additional pages or documents, as necessary)

IIC. Psychiatric medications (include total daily dose) **IID. Present and past drug/alcohol usage:**
Name of chemical Current use?

IIE. Past psychiatric treatment.

1. Number of previous inpatient admissions: ( ) Dates of most recent inpatient stay: / / to / /
2. Previous ambulatory/outpatient treatment (provider or facility, frequency)-If none, why:

III. Admitting diagnosis (Axis I):

IV. Additional diagnosis (Axis II):

Diagnosis (Axis III):

Diagnosis (Axis IV)

IV. Functional assessment scores: DSM IV (AXIS V):

VI No. of hospital days requested: ( ) Dates: / / to / /

Projected discharge date (required): / /

VII. After care plan:

Provider or facility: ________

Signature: ________

Driscoll Children's Health Plan
Psychiatric Hospital Inpatient (Extended) Request Form

615 N. Upper Broadway, Suite 1050
Corpus Christi, TX 78477

Phone (877) 455-1053
Fax (361) 653-0432

I. Identifying Information: Medicaid #: Date: / /

Last Name: First Name: Middle Initial:

Date of birth: / / Age: Sex: Date of Admission: / / Time:

Facility name: Provider#: Name of Contact Person

Commitment type:__________ Effective Dates County Judge
(If applicable)

Referral source: ( ) Admitting MD ( ) MH professional ( ) DPRS ( ) Other (list):

Name of admitting physician:

IIA. Current status of primary symptoms that require continued acute hospital care:
(Include: 1. Date of most recent occurrence: 2. Frequency; 3. Duration; 4. Severity)

IIB. Other relevant clinical information, about patient from past 72 hours:
(Attach additional pages or documents, as necessary)

IIC. Current Psychiatric medications (include total daily dose)

IID. Discharge criteria:
1.
2.
3.

IIE. Describe treatment, contacts, plans (including outcome) with family, school, etc

III. Admitting diagnosis (Axis I):

IV. Additional diagnosis (Axis II):

Diagnosis (Axis III):

Diagnosis (Axis IV):

IV. Functional assessment scores (DSM IV): AXIS V: (GAF)

V. No. of hospital days requested: ( ) Dates: / / to / /

Projected discharge date (required): / /

VI. After care plan:

Provider or facility:

Signature:____________________