Form DSH-9220 - ETP Referral Form

Identifying Information						
Patient First Name:			**Patient Last Name:**		**Patient Middle Name:**	**First Hospital Case #:**
Patient Case #:	**Referring Hospital Name:**		**DSH Admission Date:**	**Committing county:**	**Primary Legal Class:**	
Date Of Birth:	**Age:**	**Gender:**	**Sex at Birth:**	**Ethnicity:**	**Religion:**	**Primary Language:**

Referring hospital			
Staff Contact:	**Staff Phone #:**	**Staff Email:**	**Staff Job Title:**
Alternate Staff Contact:	**Alternate Staff Phone #:**	**Alternate Staff email:**	**Alternate Staff Title:**
Conservator name:	**Phone# :**	**Address:**	
Family contact name:	**Phone# :**	**Address:**	

Risk & Aggression
Current violence risk formulation (risk factors, triggers, cause of aggression, protective factors, etc):
Recent physical aggression history - (within 6 months) **General information about recent aggression**
Describe all selected recent aggression
Describe type(s) of aggression (i.e., organized, impulsive, psychotic)
Describe type(s) of aggression

Criminal History
Describe instant offense
Summary of criminal history
List any identified enemies or gang affiliations

Diagnoses, conditions & adaptive equipment

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Current Mental Health Diagnosis of Record
Diagnoses
Significant medical conditions **Current Medical Diagnosis of Record**
Medical Conditions
Descibe effectiveness of treatment
Adaptive equipment
List any adaptive equipment needed
Descibe potential impact on risk
Medications

Involuntary medication order:	

Currently prescribed medication

Medication Name	**Dose**	**Route**	**Frequency**	**Last Dose Date**

Medication Allergies:

Has the patient received a psychopharmacology resource network (PRN) consultation:	**Date:**	**Outcome:**

Other relevant information:
Has Patient been compliant with medications:
Has Patient been tried on Clozapine?
Has Patient been tried on a long acting injectable antipsychotic?:
Cognitive Functioning
Cognitive screening administered

Neuropsychological assessment completed **Yes/No**

Other relevant information regarding cognitive functioning
History of treatment for violence reduction
List all psychosocial treatment intervensions, outcomes, and barriers to treatment that have been attempted:
Psychosocial Treatment Intervention:
Barriers:
Legal Documentation

Other Information		
Any relevant patient information not captured elsewhere on this form:		
Rationale for ETP placement:		
Signature		
Employee Number	**Team members name:**	**Job Title:**
Signature: _____		**Date: _____**