ER/ED RN TO COMPLETE THIS SECTION

When complete, Fax to: 467-8107

Patient Name:
BHC/Evaluator contact:
Chief complaint & precipitating events: (include client's perception of need) and current BX:
Is patient intoxicated? □Yes □ No Is patient cognitively able to participate in evaluation? □Yes □ No BAL/BAC
History of medical issues? (i.e. HTN, Diabetes, COPD, Hx sleep apnea, etc.):
Is patient on Lithium
Is patient on Warfarin
Current vitals: B/P T R P02 Time Current labs: Pending \(\text{Yes} \) No \(\text{Results} \)
Toxicology Screening □Yes □ No Results
Current Meds: (Attach Med Reconciliation form if necessary)
Allergies/reaction (Medication, Environmental, Food, Other):
TB screen in the past year? Yes No (POS or NEG) Date read: Respiratory system issues: History of infection/TB, if yes, how treated
Does the patient require a Durable Medical Equipment? (i.e.: CPAP, cane walker, etc.)
Mobility: □Ambulatory □Non Ambulatory □Fall risk explain:
Pain? □Yes □No (explain/describe):
Cardiovascular Issues: □Yes □No GI/GU issues: □Yes □No Neurological issues: □Yes □No
Invasive lines: □Yes □No Skin issues: □
Decubitus □ Yes □ No If yes, accurate description and location:
If transferred to psychiatric unit or other facility, name of admitting Physician:
ER/ED RN Signature Date: Time:

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ER/ED PHYSICIAN TO COMPLETE THIS SECTION

When complete, Fax to: 467-8107

Patient,	, has received a basic physical		
examination at	, and has been found to be fre	ee of any acute	
life-threatening illness, or contagious diseases. As of this date, the pat	tient is deemed medically clear to be	e transported to	
SJBHC, (*a non-medical, acute psychiatric facility).			
SJBHC does not have the capability to accept patients if they requ	uire:		
•Chronic dialysis that is provided outside of service area	 Respiratory isolation 		
•IV treatments including control lines or PICC in place	 Cardiac or respiratory monitoring 		
Stage III or IV pressure ulcers	Oxygen dependent*		
 Overdoses in which there is a risk of delayed complications 	 NG tube feedings 	feedings	
(Other Psychiatric facilities may have the same or similar limitation	·		
Recommendations over next 8-12 hours: (Please specify any medicany other treatment considerations)	cation noids, repeated labs, and pre-	Cautions and	
Physician Signature			
	Date	Time	