

Specialized Needs Unit (SNU) Referral Form

Required documentation for complete packet (Please indicate all included and submitted items, download the form, and email it to arintake@desertparkway.com or fax it to (702) 776-3597.)

- SNU referral form.
- Recent psychiatric notes (e.g., psych notes, prog. note).
- Recent clinical notes indicating need for inpatient care.
- Documentation supporting an intellectual/developmental disability.

Examples includes:

- Evaluation and/or testing from a psychologist, psychiatrist, school psychologist, neuropsychologist.
- IEP/MDT that includes a summary of evaluations supporting the diagnosis.
- Past and current medication list.

***If sending supporting documents as one file, please indicate the starting page number for each section when sending the referral.**

Please complete the following information:

Referral Source

Name:

Phone:

Email:

Referral Date:

Demographics

Patient Name:

Gender:

Age:

DOB:

Where does the patient currently live (e.g., family home, group home)?

Guardian:

Relationship:

Phone:

Email:

Guardian:

Relationship:

Phone:

Email:

Insurance Provider (Primary):

Policy Number:

Insurance Provider (Secondary):

Policy Number:

Clinical

Reason for referral:

Type of behaviors occurring and frequency (check all that apply):

Physical Aggression: Daily Weekly Monthly

Verbal Aggression: Daily Weekly Monthly

Property Destruction: Daily Weekly Monthly

Self-Injury: Daily Weekly Monthly

Treatment goals:

Diagnosis:

Please indicate all listed diagnoses as indicated by the patient's medical records.

Dx Code Diagnosis

Dx Code	Diagnosis

Discharge Planning: What placement will the patient be discharged to (e.g., family home, group home)?

Plan A:

Plan B:

Who will participate in SNU caregiver training:

Medical

Check all that apply:

Seizure disorder:

Diabetes:

Fall Risk:

Asthma:

Other:

Allergies:

Dependent Care Needs

Check all that apply:

Toileting: Independent Prompted Assisted

Pull-ups: Yes No Day Night

Diapers: Yes No Day Night

Speech: Full verbal Partial verbal No verbal

Additional Information (e.g., receives speech services, utilizes a communication device):

Provider Contacts

Behavioral Health Case Manager

Name: Phone: Email:

Developmental Service Case Manager

Name: Phone: Email:

Primary Care Physician

Name: Phone: Email:

Other (e.g., medical specialist)

Name: Phone: Email:

Type of provider:

REFERRAL FORM – SPECIALIZED NEEDS UNIT (SNU)

Desert Parkway Behavioral Healthcare Hospital, LLC

3247 South Maryland Parkway

Las Vegas, NV 89109

Medication:

Please list any medications that the patient is currently taking. Include non-prescription medications & vitamins or supplements:

Name of medication: Dose: (strength & number of times per day) Start date:

Past Medications

Please list any medications that the patient has previously taken. Please include non-prescription medications & vitamins or supplements:

Name of medication: Dose: (strength & number of times per day) Start & end date:

Additional Information

Please fax this completed form and any supporting documents to our Patient Services Department.

(702) 776-3597

If you have any questions about the referral process, please contact us at our 24/7 admission line:

(877) 663-7976