DESERT PARKWAY
Behavioral Healthcare Hospital

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 alv.snu@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: _____

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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

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:

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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:

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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