Siouxland Mental Health Crisis Center
4038 Division St. Sioux City, Iowa 51104 Phone 712-560-7996 Fax 712-560-9202
REFERRAL FORM

The Siouxland Mental Health Crisis Center has a low to intermediate residential level of care for adults 18 years old and older, who are in crisis, do not meet criteria for in-patient mental health services, and need short term observation and/or stabilization. Additionally, The Siouxland Mental Health Crisis Center has community based services for individuals of any age, who are in a crisis, do not meet criteria for in-patient mental health services, and need short term stabilization.

This is a voluntary program, individuals may leave at any time for any reason. If an individual is under a court order, the appropriate authorities will be notified. Clients will be released upon stabilization of their crisis, regardless of housing situation. Individuals can be court ordered to The Siouxland Mental Health Crisis Center. If you would like to make a referral for any service please call the Crisis Center Staff at 712-560-7996 and then complete and fax the form to 877-686-2801 OR 712-560-9202.

At least one of the following criteria must be met to constitute a mental health crisis:

- Individual shows mental health discomfort and/or increased mental health symptoms that significantly interfere with ADLs (Activities of Daily Living) that require immediate treatment.
- Individual is experiencing a crisis involving an abrupt change in normal functioning caused by a specific cause/event/stressor with a concurrent psychiatric issue.
- Individual is ineligible for inpatient hospitalization.

At least one of the following criteria may ***prohibit*** the individual from admittance:

- Acute medical condition. ***SMHCC is not a medical facility and is unable to accommodate a client with an unstable medical condition.*** **Note individual may be monitored and screened for later acceptance of admission.*
- Physical disability preventing individual to care for self. The facility is ADA accessible.
- Resides outside of Rolling Hills, Care Connections of Northern Iowa or Sioux Rivers Regional Counties (If individual resides outside these counties, please call for exceptions).
- Actively psychotic and unable to comprehend simple commands
- Actively suicidal and/or homicidal with plan/intent to harm/kill others.
- High risk behavior of violence in the past 48-72 hours- ****History of violence must be disclosed***

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REFERRAL INFORMATION

Patient Full Name:_____ DOB:_____

Social Security Number: _____-_____-_____ Sex: _____ Race: ____ Height/Weight: _____

Address: _____
(If homeless please write Homeless and the last known residence, and the shelter they are staying at, if applicable)

Phone number: _____

County of Residency:

☐ Woodbury	☐ Buena Vista	☐ Calhoun	☐ Carroll	☐ Cherokee
☐ Crawford	☐ Humboldt	☐ Ida	☐ Pocahontas	☐ Sac
☐ Dickinson	☐ Emmet	☐ Lyon	☐ O'Brien	☐ Plymouth
☐ Sioux	☐ Clay	☐ Osceola	☐ Palo Alto	☐ Kossuth
☐ Winnebago	☐ Worth			

- INDIVIDUAL MUST BRING ALL **INSURANCE** INFORMATION/CARDS/ID.
- MUST PROVIDE **PAYEE** INFORMATION IF APPLICABLE.

Insurance: _____ Medicaid MCO: _____

Additional Insurance: _____

Does the individual have a Legal Guardian or Power of Attorney: ☐Yes ☐ No

If yes, who/contact information: _____

Emergency Contact: _____

Referring Individual & full contact Info: _____

If hospital discharge: List pertinent medical information, discharge planning, follow-up information:

_____

_____

Please FAX the following list of clinical information (*all available*):

☐ Lab Work
☐ Electronic medication administration record or current medication list
☐ Vitals
☐ History and physical, most recent primary care physician note, and/or ER summary
☐ Psychiatric Evaluation

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Which program(s) is the individual being referred to:

☐ 23-Hour Observation and Holding

☐ Subacute Mental Health Services

☐ Crisis Stabilization Residential Services

☐ Crisis Stabilization Community Based Services

Reason for Referral (Mental Health Crisis: Anxiety, Depression, Suicidal Ideation, Medication Management, Grief, Sudden Event or Severe Stressor):

_____

_____

_____

_____

Check all of the following behaviors that apply:

Manic Behavior ☐	Threatening Others ☐	Paranoia ☐	Delusional Thinking ☐
Borderline Traits ☐	Depression ☐	Anxiety ☐	Aggressive Behaviors ☐
Self-Harm ☐	Antisocial ☐	Auditory Hallucinations ☐	
Visual Hallucinations☐	Homicidal Ideation ☐	Suicidal Ideation w/ Plan, Intent, and/or means ☐	

Please explain any items checked above. Indicate current or past.

_____

_____

_____

☐ I have reviewed the material and I believe that the individual is appropriate for crisis services at Siouxland Mental Health Crisis Center.

Referring Provider and Agency: _____ Date: _____
*** MD, DO, PsyD, LMSW, LISW, LMHC, LMFT, ARNP, PA*

Please complete and fax to 877-686-2801 OR 712-560-9202.