Boston Children's at Waltham Community Based Acute Treatment (CBAT) Program

Inquiry for Admission

Today's date: _____
Requested admission date: _____

Referral source: What is your relationship to the patient? _____

Please share your contact information (Name/phone/email): _____

Patient name (legal): _____ **Age:** ___ **Date of birth:** _____ **Gender:** _____

Patient name (chosen/preferred): _____

Address: _____ **City:** _____ **State** _____ **Zip:** _____

Parent/guardian 1 name: _____ **Parent/guardian 1 phone:** _____

Parent/guardian 2 name: _____ **Parent/guardian 2 phone:** _____

Primary insurance carrier: _____ **ID number:** _____

Secondary insurance carrier: _____ **ID number:** _____

DCF involvement:

- ☐ **None**
- ☐ **Current**
  Case worker and office: _____
- ☐ **Past: Lists date(s)** _____

Treatment Goals for requested CBAT Admission:

Boston Children's Waltham

Current History

Allergies: *(List all food and medication reactions)*	**Reaction:**

Current Medications: (please include vitamins, supplements and over the counter medications)

Medication name:	**Dose:**	**Frequency and schedule:**

History of present illness:

Current psychiatric diagnoses:

Please list active medical conditions and treatment needs:

What is this patient's disposition plan after completing of CBAT treatment? (i.e. Partial Hospital Program, home with outpatient and school supports, out of home placement)

_____

Current outpatient services (name of agency or provider and contact information for ongoing providers & referrals that have been made):

Provider	Phone/Email	
		☐ Referral in progress ☐ Current provider
		☐ Referral in progress ☐ Current provider
		☐ Referral in progress ☐ Current provider
		☐ Referral in progress ☐ Current provider

Please check if any of the following interventions have been needed the past 72 hours:

☐ 1:1 supervision
☐ Pocket Checks
☐ Open Areas
☐ Bathroom Checks/ verbal bathrooms
☐ Post-meal bathroom restriction
☐ Monitor calorie or fluid intake
☐ Locked clothing or no access to sheets and linens
☐ Meal supervision
☐ Continuous overnight supervision
☐ Medication Restraint
☐ Bed/Chair Restraint
☐ Physical Hold/Escort

Has the patient required the use of IM medications, restraints/LDS at during past or present hospitalization? _____

If yes, please describe details below including date of last event:

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Past History

Medical and Psychiatric Hospitalizations:

Reason for Admission:	**Date(s)**

Clinical Events		Please Include details and dates:
Elopement	☐No ☐ Yes	
Suicide attempt(s)	☐No ☐ Yes	
Suicidal Ideation	☐No ☐ Yes	
Self-Injury requiring treatment	☐No ☐ Yes	
Purging	☐No ☐ Yes	
Food Restriction	☐No ☐ Yes	
Medication non-adherence	☐No ☐ Yes	
Property Destruction	☐No ☐ Yes	
Verbal Aggression	☐No ☐ Yes	
Assault or Battery	☐No ☐ Yes	
Fire setting history	☐No ☐ Yes	
Sexualized behavior	☐No ☐ Yes	
Legal Charges/DYS custody	☐No ☐ Yes	
History of long-term psychiatric placement (such as IRTP or CCU)	☐No ☐ Yes	