NEW YORK STATE OF OPPORTUNITY. | Elmira Psychiatric Center

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Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

DAVID PEPPEL
Executive Director

Children's Crisis Respite Residence

Crisis Planned Assessment Summary Admission Decision

EPCChildrenCR@omh.ny.gov

Phone: (607) 737-4990 Fax: (607) 737-4880

Cell 1: (607) 481-8234 Cell 2: (607) 481-8454

Contact Information

Child's Name: _____ DOB: _____ Age: _____

Child's Address: _____

City/State/Zip _____ County: _____

School District: _____ School Contact Number (Fax or Phone#): _____

Insurance Information: _____

Parent/Guardian Name: _____ Contact Number: _____

24 Hour Emergency Contact: _____ Contact Number: _____

Referral Source (Name and Title): _____ Referral Agency: _____

Referral Source E-mail: _____ Phone Number: _____

Criteria for Acceptance

[ ] The child has reached his/her 10th birthday but has not reached his/her 18th birthday.
[ ] The child has a designated mental illness diagnosis.
[ ] The child is not currently under the influence of alcohol or drugs.
[ ] The child is considered medically stable for the program (i.e., no evidence of acute illness/disease).
[ ] The child is capable of self-preservation/evacuation of building during an emergency.
[ ] The child is capable to self-administer his/her medications with supervision.
[ ] The child is not an imminent danger to self or others.

Explain any of the above criteria which the child does not meet:

Crisis/Planned Assessment & Admission Summary

Child's Name:

Child Information

Referral Date: _____ Referral Time: _____

Anticipated Admission Date: _____ Anticipated Discharge Date: _____

Does the child receive Waiver Services? Yes [ ] No [ ] If no, please continue.

If yes, have you exhausted all other respite options in the area? Please explain.

DSM Diagnosis: _____

Is this a Crisis or a Planned Respite? [ ] Crisis [ ] Planned Respite

Describe the crisis situation or need for planned respite:

Alerts: (Please include all mental health, behavioral, and/or sensory issues that we need to be aware of so we can provide effective support and supervision for the youth.)

Current Medications

Name:	Dose	Route	Frequency	Date/time of last dose

Crisis/Planned Assessment & Admission Summary

Child's Name:

Allergies: _____

Type of reaction: _____ Treatment for reaction: _____

History

History of Psychiatric and Behavioral Concerns:

_____

_____

_____

History of Medical, Trauma, and/or substance abuse concerns:

_____

_____

_____

Treatment

Recommendations for treatment while at the Crisis Respite Residence.

_____

_____

_____

What are the anticipated discharge needs for the child and family?

_____

_____

_____

Please list all agencies and services family receives related to this child's care:

_____

_____

_____

Crisis/Planned Assessment & Admission Summary

Child's Name:

For EPC CCRR use only:

Reviewed by: _____

Date: _____ Time: _____

[ ] Accepted [ ] Declined – Reason: _____
