Patient Label

☐ Acute ☐ PRTF ☐ PHP ☐ IOP

LIGHTHOUSE CARE CENTER OF AUGUSTA

Application and Checklist

The following admissions checklist is to be used as a guide when sending referral information to LCCA. Each packet received is reviewed by our Admissions Clinical Team to determine appropriateness for the program. It is essential that we receive documentation that is current and presents and overall picture of the potential patient. This information is needed prior to admission of a patient.

We appreciate your support and look forward to working with you. Should you have any questions, please do not hesitate to call Admissions at (706)651-0005. Please make sure that your packet contains as much of the following information as possible:

SOCIAL and PSYCHIATRIC SUMMARY

- Social History*
- Psychological and/or Psychiatric Evaluations*
- Previous treatment/placement history(staffing reports, discharge summary, treatment places, progress reports, etc.)*
- Current behavioral functioning: strengths, talents and problems
- Custody status (If patient’s guardian is not patient’s biological parent, guardianship paperwork is required)*

PHYSICAL EXAMINATION

- Immunization record
- TB Test
- Last Dates of Dental, Vision or Gynecological visits
- Health Physical
- General physical condition; nutritional requirements; or allergies.

EDUCATION

- Current grade and report card, school transcripts
- Students eligibility for Special Education placement*
- Educational evaluation and test scores, if any
- Individualized Education Program (IEP), if identified as special education*

- Indicates that these items are deemed essential.

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LIGHTHOUSE CARE CENTER OF AUGUSTA

Application for Admission

Part I

Resident's Name:

____

Last First Middle

Resident's Address: ____

Street

____

City State Zip Code Home Phone

Sex: ______ **Age:** _______ **Birthdate:** _____________________ **Birthplace:** ____________________

Race: ___________________________ **Religious Preference:** __________________________________

Resident's Social Security Number: ____

Resident being admitted from: Home ________ **Hospital** ________ **Other** ________

If other than home, give name, address, telephone number of facility: ________________________

____

____

Name and Address of Legal Guardian, if not parent: ______________________________________

____

____ **Phone Number:** ____________________________

Reimbursement Source(s): **( ) GA Medicaid( ) Amerigroup ( ) WellCare**
(check all that apply) **( ) Cenpatico ( ) SC Medicaid ( ) Private Insurance**
( ) State Agency ( ) Private Pay

Specific Insurance Information (company/agency name, policy ID#, Claims address, authorization#, subscriber name, SSN and DOB, etc. Please include a copy of the card.):

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____

Referral Source Name: ____________________________ **Location:** __________________________

Phone/Email: ____

Contact Preference: Phone ______ **Email** ______ **Fax** _____ **If fax, fax#** ______________________

How did you hear about us? ____

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Part II – Social – Developmental Summary

Resident's Name: ____

Father's Name: __________________________ **Home Phone:** ___________________

Address: ____

Employer: ______________ **Occupation:** _________ **Work phone:** _________________

Father's SSN: __________________________ **Father's DOB:** ___________________

Marital Status: ________________

Mother's Name: __________________________ **Home Phone:** ___________________

Address: ____

Employer: ______________ **Occupation:** _________ **Work phone:** _________________

Mother's SSN: __________________________ **Mother's DOB:** ___________________

Marital Status: ________________

Brothers/Sisters: ________________________________ **Age:** _________

________________________________ **Age:** _________

________________________________ **Age:** _________

________________________________ **Age:** _________

________________________________ **Age:** _________

Brief Description of family relationships: ______________________________________

____

____

Current behavioral functioning (strengths, talents, problems): _______________________

____

____

Documentation of need for care apart from the family setting: _______________________

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Legal Involvement: ____

____

Protection needs specific to applicant: ____

History of Physical/sexual abuse/trauma or exploitation with the applicant:

____

____

Axis Diagnosis (if known):

DSM-V/IC D-10 Codes
Clinical disorders

Diagnostic code	DSM-V Name
__________	______________________________
__________	______________________________
__________	______________________________
__________	______________________________

General Medical Conditions

ICD-10-cm code	ICD-10-CM Name
__________	______________________________
__________	______________________________
__________	______________________________
__________	______________________________

Expectations / Treatment Goals for Patient while at LCCA: ______________________________________

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Alternative placements/services utilized in the past, please list most current first.

Setting (i.e. outpatient, in-home, mentoring, residential, acute, etc.)	Dates (Began-Ended. i.e. June 2015-December 2015)	Successful
1.)		Y N
2.)		Y N
3.)		Y N
4.)		Y N
5.)		Y N
6.)		Y N
7.)		Y N

If not successful, please explain reason for failure?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

Part III – Educational

School Attending: ______________________________ **Grade:** _________

School Address: ______________________________

Telephone Number: ______________________________ **Contact Person:** ______________________________

IEP Developed By (Send current copy): ______________________________ **IEP Date:** __________________

Current Scheduled Classes: ______________________________

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Educational Needs Specific to this applicant: ____

____

____

Full Scale IQ: ______________________ **Test Administered:** ____________ **Date:** ___________

Part IV – Medical History

1. **Height____ feet _____ inches Weight ________ lbs**

2. **Describe any serious illnesses or chronic conditions of applicant's parents and siblings, if known: Check if applicable ( ) NONE ( ) UNKNOWN** ______________________________

   ____

   ____

3. **Please describe the following about the applicant:**

   a. **Past serious illnesses or infectious diseases (name of disease, duration, etc.):** ___________

   ____

   ____

   b. **Serious injuries:** ____

   c. **Impact of any of these on current health:** __________________________________

   ____

   d. **Physical Handicaps:** ____

   e. **Visual Disorders:** ____

   f. **Hearing Problems:** ____

   g. **Suffers from Enuresis (frequent urinary accidents either during the dat or at nighttime – please describe):** ____

   ____

   h. **Suffers from Encopresis (inability to control elimination of stool/intentional or unintentional soiling of pants – please describe):** _____________________________________

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i. **Child is not able to perform the following activities of daily living: ____________________**

____

4. **Current Medications:**

Medication	Dosage	Frequency	Prescribed By	Compliant
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N

5. **Past Medications Used: ____**

____

6. **Food Allergies: Yes ______ No ________ Describe: ____________________________________**

7. **Drug Allergies: Yes ______ No ________ Describe: ____________________________________**

8. **Does applicant have any history of substance abuse? Yes ______ No ________**

Describe (If yes, please give name of drug and any facts surrounding use i.e. length of use, frequency, treatment):

____

____

____

____