



Long Term Care Referral Screening Form

Level of Care Requested (Select one. A referral form is needed for each level of care):

☐ MHRC/STP ☐ SD County Funded SNF ☐ SNF Patch ☐ NBU Patch ☐ State Hospital

Please review criteria for each level of care on optumsandiego.com if needed.

Facility Information

Referring Facility:		Admit Date:	
Contact Name:		Phone:	Fax:

Client Information

Client's Name:		Date of Birth:		Age:	
Gender: ☐ M ☐ F ☐ O	Race:	Marital Status:	1 st Language:	2 nd Language:	
☐ SSI	☐ Medicare #		TB Test Date and Result:	Allergies:	
☐ SSA	☐ Medi-Cal #				
☐ SSDI	☐ Regional Center		UDS at Admission:	BAL at Admission:	
☐ Other	☐ VA Benefit				

Conservatorship Information

Conservatorship (**Required**)	Date Established:
☐ Temporary ☐ Permanent ☐ Public ☐ Private	
Conservator/Court Investigator:	Telephone #:

Comments on Court Investigation:

Case Manager:	Telephone #:
Payee:	Telephone #:
If NO Payee, has an application been made for Payee Services?	Date of Application:

Diagnosis Information

Use DSM/ICD diagnosis and other clinical or medical considerations

Primary Diagnosis:	ICD Code:
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TBI/NCI, DD, Intellectual Disability Diagnosis:	Other Diagnosis, Infectious Diseases, and/or Special Needs (Clinical or Medical):
Risk Factors	
Current Risk Factors (Explain the rationale when numbering the “Current Risk Factors” below):	
Historical Risk Factors:	
Current Dangerous Propensities:	Historical Dangerous Propensities:
Current Risk Factors	Weak —————→ Strong
Weak to Strong	12345
Suicidal Risk	☐☐☐☐☐
AWOL Risk	☐☐☐☐☐
Assaultive Risk	☐☐☐☐☐
Drug/ETOH Risk	☐☐☐☐☐
Sexual History Risk	☐☐☐☐☐
Referral Information	
Reason for Referral to This Level of Care (Why does the client need this level of care?):	
Current Treatment (Response to treatment, medication compliance, participation in groups, etc.):	
History of Prior Hospitalizations/IMD/State Hospital/SNF Treatments (Include dates):	
Living Situation for Past 12 Months:	
Legal issues (Note any probation, warrants, or interaction with legal system):	
Psychiatrist Information	
Treating Psychiatrist Signature:	
Printed Name of Psychiatrist:	Phone:

***Please refer to the “Tips for Completing the LTC Referral Screening Form” which can be found on the Optum San Diego Website (<https://optumsandiego.com>) for more information.