



## North Coast Crisis Respite Center

326 SW Marlin Ave. Warrenton, OR 97146

nccrcferrals@clatsopbh.org Fax 503-861-5649

### Respite Referral Process

Thank you for your referral! NCCRC is a short-term program for individuals who do not need emergency room or a hospital level of care and have a mental health diagnosis. We do not have medical staff on-site and will ask you to follow the process below to assure your client is getting the best and most appropriate level of care.

- 1) Email [nccrcferrals@clatsopbh.org](mailto:nccrcferrals@clatsopbh.org) . Please have demographic and insurance information available. We will want to know the client's goal for their respite stay.
- 2) *Send Assessment:* If we have an available bed, and the individual looks appropriate, we will ask for:
  - a) A current Behavioral Health Assessment, Psychiatric Evaluation, or History & Physical.
  - b) Recent progress notes that demonstrate symptoms related to primary diagnosis ( if notable).
  - c) List of current psychiatric and physical health medications including over- the- counter medication.
- 3) *NCCRC Reviews and Authorizes Admission:* We will do our best to review the documents and authorize admission within one day of your initial referral.
- 4) *Send Health Screen Form and Medication Orders:* **Once admission to respite has been authorized, we will contact you and request:**
  - a. *Health Screen Form* (Signed and dated by MD, PMHNP, or PA. A RN can sign for a verbal order of the Health Screen Form from qualified professionals) And ;
  - b. Current signed/dated *Medication Orders* signed and dated by MD, PMHNP, or PA, for:
    - i. Any psychiatric medication the client is bringing to respite.
    - ii. Any physical health medication the client is bringing to respite.
    - iii. Any over- the- counter medication the client is bringing to respite.
    - iv. Any durable medical equipment the client is bringing to respite (i.e., diabetes equipment or needles).
- 5) *Set Admission and Case Management Plan:* We will arrange an entry day/time for the individual. We ask that community providers connected with the client's stabilization during and after their respite stay maintain contact regarding care coordination and discharge planning. *We will set an interdisciplinary team meeting at 4:00 PM the next business day following admission.*

***Please Note: We cannot finalize an admission until we receive signed medication orders and a signed NCCRC medical screening form. Instructions for medication orders and the medical clearance form are included in this referral packet.***

Send all documentation via email [nccrcferrals@clatsopbh.org](mailto:nccrcferrals@clatsopbh.org) or FAX to 503-861-5649.



## North Coast Crisis Respite Center

326 SW Marlin Ave. Warrenton, OR 97146

nccrcferrals@clatsopbh.org Fax 503-861-5649

### Clinical Guidelines for Respite

Respite authorizations are done on a case-by-case basis. Listed below are guidelines for appropriateness of utilization of NCCRC services. The individual would not have to fit all the criteria below to be eligible.

#### The individual:

- Is diagnosed with a mental illness (OHP-covered diagnosis), excluding mental disorders due to a general medical condition.
- Is unable to care for basic needs due to psychiatric difficulties at current living situation.
- Needs further stabilization due to recent medication adjustment.
- Needs a supportive environment for new medication change.
- Is unstable due to not taking medications as prescribed and is willing to take medications as prescribed while at NCCRC.
- Feels unsafe towards self because of current psychiatric condition/current stressors and is willing to verbally commit to safety to self and others while at respite including a willingness to let staff at NCCRC know if symptoms are creating a need for a higher level of care.
- Does not possess an unstable medical condition that requires 24/7 monitoring or specialized nursing level of care needs.
- Needs a break from current living situation, which appears to be increasing psychiatric symptoms.
- Is not experiencing acute withdrawal symptoms.
- Does not need 24-hour acute care and counseling services, but needs a temporary safe, supportive environment.
- May be excluded for consideration based on recent history of physical assault, homicidal behavior, arson, sexual offenses, weapon possession, or anti-social behaviors.



## North Coast Crisis Respite Center

326 SW Marlin Ave. Warrenton, OR 97146

nccrcferrals@clatsopbh.org Fax 503-861-5649

### NCCRC Health Screening Form

Client Name: \_\_\_\_\_ Client ID \_\_\_\_\_

A health screening or a waiver of the health screening is required for admission to NCCRC services. Oregon Administrative Rule 309035-0175(2)(c)(A)-(C) states: "For individuals experiencing psychiatric or medical distress a health screening shall be completed by a Licensed Medical Professional or other qualified health care professional prior to the residents admission. The health screening shall confirm that the individual does not have health conditions requiring continuous nursing care, a hospital level of care, or immediate medical assistance. The health screening criteria may be waived for individuals admitted for NCCRC services are under the active care of an LMP or other qualified health care professional if it is the opinion of the attending health care professional that the NCCRC placement presents no health risk to the individual or other residents in the facility. Such a waiver must be provided in writing and be signed and dated by the attending health care professional. For each NCCRC resident who continues in the facility for more than seven consecutive days, a complete health examination shall be arranged if any symptoms of a health concern exist. A separate form will be required and filed in the residents chart"

**Please initial one of the following as applies to the above-named client:**

- The above-named client has been given a health screening and is appropriate for admission to NCCRC services.
- I hereby waive the health screening. The above-named client is appropriate for admission to NCCRC services.
- The above named client has permission to take medications in their possession at the time of discharge from NCCRC.

\_\_\_\_\_  
Licensed Medical Professional Name (printed)

\_\_\_\_\_  
Name of Facility

\_\_\_\_\_  
Licensed Medical Professional Signature

\_\_\_\_\_  
Date