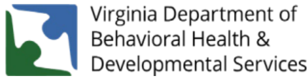

Application for Services

Admission to Southeastern Virginia Training Center

Emergency Admission (12 VAC 35-200-30)

This form is to be completed by a staff member of the Community Services Board responsible for pre-screening. It is to include medical, social, psychological and educational/vocational reports for the admission of any person to a state training facility in accordance with section
37.2-807 of the Code of Virginia.

CSB: ____________________ CSB Support Coordinator: ____________________

Contact Information: Phone: Office ______________ Alt: ______________ Fax: ______________

CSB Support Coordinator Email Address: ____________________

Individual's Name: ____________________ DOB: _____/_____/_____ Male ☐ Female ☐

SSN: _______- _____- ________ Medicaid #: ____________________ Date(s) of previous admissions and facility name:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current Residence: ____________________

Contact Information: ____________________

Legal Status: ☐ Guardian ☐ Authorized Representative ☐ Self-Representation

Name of Guardian/Substitute Decision Maker (SDM): ____________________

Relationship to Individual: ____________________

Address: ____________________ Phone #--------------------_______

Is the SDM willing to continue to fulfill this responsibility while the individual is in a training center? ☐ Yes ☐ No

Reason for Admission Request:

Cultural Preferences

Food: ____________________

Dress: ____________________

Medical Treatment: ____________________

Religion: ____________________

Other: ____________________

Linguistic Preferences

Language Spoken: ____________________

Language Understood: ____________________

Preferred Language: ____________________

Comments:

Individual Requires: ☐ Acute Psychiatric Treatment ☐ Medical Treatment

☐ Behavioral Treatment ☐ Medication/Pharmacological Review

Diagnoses:

Level of Developmental Disability: ________________ Determined by (type of testing, etc.): ____________________

Date of Testing: _____/_____/ _____

Psychiatric:

Axis I: ____________________

Axis II: ____________________

Medical: ____________________

Attending Physician: ____________________ Phone # --------------------_______

Community Psychiatrist: ____________________ Phone # ------------------- _______

Current Pharmacy: ____________________ Phone # ------------------- _______

Comments:

Hospitalizations during the last two years (attach information if available):

Hospitalization ____________________

Psychiatric Hospitalization ____________________

Surgery ____________________

Comments:

Immunizations: DT: _____ /_____ / _____ Last PPD: _____ /_____ / _____ PPD Result: ____________________

Flu: _____ /_____ / _____ Pneumonia: _____ /_____ / _____ H1N1: _____ /_____ / _____

Hepatitis B: 1st ______/______/ ______ 2nd ______/______/ ______ 3rd ______/______/ ______ Other: ____

Dietary Needs/Special Requirements (Diet Order):

Food Allergies: ____

Current Medications	Reason (Attach MAR)	Current Medications	Reason (Attach MAR)

Medication Allergies:

Psychiatric Medication History (For the last two years if Available):

Sexual History: Last Menstrual Cycle: ______ /______ / ______

Are there any criminal charges pending? ☐ Yes ☐ No If yes, explain.

Based upon your knowledge of the individual, is he/she capable of requesting his/her own admission to the facility? ☐ Yes ☐ No

Presenting Issues (behaviors, goals, abusive problems, substance use, etc.):

Community Residential Providers/Placements during the last two years (include date resided with provider):

____________________ From: _____ /_____ / _____ To: _____ /_____ / _____

____________________ From: _____ /_____ / _____ To: _____ /_____ / _____

____________________ From: _____ /_____ / _____ To: _____ /_____ / _____

____________________ From: _____ /_____ / _____ To: _____ /_____ / _____

____________________ From: _____ /_____ / _____ To: _____ /_____ / _____

____________________ From: _____ /_____ / _____ To: _____ /_____ / _____

Alternative Community Options Explored:

Has this individual been referred to the Regional Support Team? ☐Yes ☐No

Date of the meeting ______/_______/________

RST Recommendations and outcomes:

Education (if under age 22):____

Activities of Daily Living (ADL) Skill Level/Supports Needed With Personal Care:

Adaptive Devices Used: ☐ Wheelchair ☐ Helmet ☐ Eating Utensils Other: ____

Comments:

Individual's Likes (or attach current Person-Centered Plan)	Individual's Dislikes (or attach current Person-Centered Plan)

Outline Preliminary Discharge Plans and Post-Discharge Follow-Up, (may be required by the individual upon return to the community):

Date Completed: _____ /_____ / _____

Facility Fax #: _____-_____-______

Community Services Board (Name): ____

Case Manager (Print): ____

Case Manager Signature: ____

Required Attachments:

- ☐ Free of Communicable Disease Statement
- ☐ Current Psychological - 12VAC 35-200-20 (4)
- ☐ Social History - 12 VAC 35-200-20 (3)
- ☐ IEP for School Aged Children - 12 VAC 35-200-20 (5) I
- ☐ ISP
- ☐ SIS (if currently in Waiver or ICF/DD Services)
- ☐ Vocational Assessment - 12 VAC 35-200-20 (6)
- ☐ Statement from CSB regarding arrangements to return to community pursuant to 12 VAC 35-200-20 (8)
- ☐ Statement from the individual, a family member, or AR specifically requesting services in the training center - 12 VAC 35-200-20
- ☐ Copy of court order for guardianship if individual has a legal guardian