SmartHealth

Adult Medical Clearance Automatic Referral Form

The **Ascension Illinois- Foglia Family Foundation Residential Treatment Center** maintains a voluntary admission process. As such, we will accept an automatic referral if the following is met:
(1) none of the Exclusion Criteria outlined below are applicable to the patient;
(2) this form must be completed and signed by a clinician. Please fax the completed form to:
Ascension Illinois- Foglia Family Foundation Residential Treatment Center - (Fax to Intake at 847-981-6080);
(3) verbal consent has been obtained from one of our Intake Professionals.

Date: _____

Patient Name: _____ Provider Name: _____

Location: _____

EXCLUSION CRITERIA

YES	NO	
		Age less than 18 years old.
		Patient does not voluntarily consent to admission or treatment.
		Court mandated treatment.
		Patient has a guardian.
		Patient is on a controlled substance (e.g. opioids, psychostimulants, benzodiazepines, medical marijuana) and does not agree to taper schedule.
		Imminent danger to self/others, or acute psychosis requiring inpatient psychiatric treatment.
		Patient requires acute detoxification.
		Patient behavior may compromise the safety of the milieu environment.
		Patient is unable to perform Activities of Daily Living or needs custodial care beyond capability of RTC setting (e.g. quadriplegic, tracheostomy, ventilator, etc.).
		Patient has medical condition or impairment that may hinder participation in RTC service or requires routine care that is beyond the capability of the RTC setting.
		Patient has an intellectual deficiency below IQ 70 that would prevent him/her from treatment participation.
		Treatment is being used for purpose of convenience such as avoiding incarceration or alternative housing.
		History of physical/sexual violence, fire setting or discharge from another program for aggression.

ADDITIONAL EXCLUSION CRITERIA

Related to Alcohol and Drug Intoxication /Withdrawal			*Related to vital signs Ranges and Medical Stability*		
YES	**NO**		**YES**	**NO**	
		Is blood alcohol level (serum or breathalyzer) >.03?			SBP <80 or >180 or DBP >110?
		Are hallucinations, autonomic instability or alcohol withdrawal related loss of orientation present?			Heart rate <50 or >130?
		Was naloxone used in the last 4 hours? Or is opioid-related respiratory depression or loss of consciousness present?			Respiratory rate >24?
		Is methadone maintenance > 30 mg per day?			Temp > 100.4?
Related to psychiatric stability					Blood Glucose <60 or >300?
		Is the patient actively suicidal?			
		Is the patient actively homicidal?			
Related to Activities of Daily Living and Motivation:					
		Patient is willing to participate in treatment and understands that a commitment of up to 28 days of inpatient care beyond detox may be required.			Is IV management of any kind needed?
Related to Covid Status			***Related to abnormalities on physical examination***		
		Has the patient received a COVID 19 vaccination?			Acute physical trauma?
		Vaccine type-please circle. Pfizer, Moderna, Johnson & Johnson Vaccination Date: Dose 1._____ Dose 2._____			Abnormal breath sounds?
		Has the patient had a negative COVID PCR test within 3 days of anticipated travel/admission date? Date _____			Cardiac arrhythmia?
		Has the patient had a negative COVID PCR test upon admission?			Acute chest pain? Abdominal pain?

		Date of Test _____			
		Does the patient have symptoms associated with Covid19?			Severe jaundice/cyanosis of skin?
					Severe lethargy?
					Stupor, delirium, meningeal signs?
					Acute influenza in the last 7 days?

Next Steps:

Please sign below denoting that none of the exclusionary criteria are present in the patient at the time of referral.

_____	_____	_____
Provider Signature	**Date**	**Telephone Number**