UNC HEALTH CARE
WAKEBROOK

Referral Agency: _____
Referral Contact Name/Phone_____
_____
Referral Date/Time: _____

REQUEST FOR ADMISSION FORM
PHONE: 984-974-4800 FAX: 984-974-4913

Patient Name:_____
Date of Birth(Must be 18 for Admission) :_____

Wake County Resident? **O** YES **O** NO (Needs to be Wake County Resident for residential detox or crisis services)

Address:_____ Phone _____
_____

Guardian Name/Phone, if applicable: _____

Medicare:_____ Medicaid:_____ Other/Self Pay _____

Admission Status: **O** VOLUNTARY **O** INVOLUNTARY
Patient willing to take oral meds for treatment**:** **O** YES **O** NO

Referring to **O** Acute Inpatient **O** Alcohol/Drug Detox **O** Facility Based Crisis (mental health and/or SA – can take IVSs)

Brief Description of Problem:_____

_____

Aggressive/disruptive behaviors (***please describe***)*:*_____

_____
Diagnoses: _____
Current Meds: _____
_____
Medical problems: _____

Labs: **O** Within normal limits (see DSOHF guidelines) **O** Not Completed **O** UDS/BAC: _____

Pregnant? **O** NO **O** YES, # weeks _____ **O** Other Abnormalities: _____

Vital Signs: T_____ P_____ BP_____ RR_____

History of seizures/DTs? **O** Yes **O** No

Pending/past legal problems:

_____

ADLs: **O** Independent **O** Feeding **O** Bathing **O** Walking (specify assist device)