Version: 2/27/2024

Care Traffic Control (CTC) Referral Checklist

PATIENT NAME: _____ **DOB*:** _____

**Patients referred to CTC on IEA or RCD/CDR must be aged 18 & over*

Referring facility/ location: _____

Referring clinician and phone #: _____

24 x 7 contact information at hospital and/or CMHC (required): _____

_____

Patient current location (hospital/unit/floor): _____

*DRF & Bed Assignment (if patient already accepted & bed is available): _____

**(Identify hospital with internal DRF bed: Concord Hospital Franklin, Elliot, Parkland, or Portsmouth)*

ALL REFERRALS FOR ADMISSION MUST INCLUDE THE FOLLOWING INFORMATION

PATIENT INFORMATION

☐ Name, Chosen Name, Address, City, State, Zip, Phone
☐ Biologic Sex and Gender Identity
☐ Hearing Impairment ☐ Preferred Language _____ ☐ Interpreter Need

LEGAL DOCUMENTATION FOR HOSPITALIZATION

Check all that apply:

☐ IEA Petition or ☐ Conditional Discharge Revocation or ☐ 612 Transfer
☐ Bail Order (if coming from jail)
☐ Community Commitment
☐ Other Relevant Legal Documents including JPPO, DCYF
☐ Legal Agent Activated Documentation: ☐ Guardian ☐ DPOA

MEDICAL

☐ H&P
☐ Current Medication List
☐ COVID-19 Antigen Test
☐ Vital Signs
☐ Required Lab Results: CBC, CMP, HCG, U/A, UTOX (or Provide Documentation for Refusal)
☐ Diagnostic Tests, Reports & Printouts
☐ Medical Devices and/or Adaptive Equipment
☐ Self-Care/ADLs

BEHAVIORAL HEALTH

☐ Psychiatric Diagnosis
☐ Psychiatric Consult / Assessment w/ MSE, (include Mini-Cog for 60 years & older)
☐ High Risk Factors (Violence, S/I, H/I, SIB, Elopement, Detox, Seizure Hx, Use of Restrictive Measures)

FORWARD ALL INFORMATION INCLUDING THIS PAGE TO CTC:

PHONE: (603)271-5364 **FAX: (603) 271-5723** **ENCRYPTED EMAIL:** nhhadmissionsoffice@dhhs.nh.gov

Printed copies of this form are for reference ONLY. Please refer to the electronic copy for the latest version:
https://www.dhhs.nh.gov/about-dhhs/locations-facilities/new-hampshire-hospital/nhh-involuntary-admissions