

**Initial Hospitalization Authorization Form for Youth (under age 18 year)**

Form must be faxed to MHRB: (513) 695-1776

Questions? Call Amanda Peterson, Deputy Director at 513-695-1695

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Date: \_\_\_\_\_ Location of Crisis Service: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Address: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Name and Contact information of Parent/Guardian: \_\_\_\_\_

Is the patient uninsured?  Yes  No

Has the patient been receiving outpatient behavioral health services?  Yes  No

If yes, the last date services were received: \_\_\_\_\_

Name of agency, case manager and psychiatrist:

\_\_\_\_\_  
\_\_\_\_\_

Reason for admission to hospital? (include dates, identifying data, pertinent past history - med, psych & CD):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current condition/MSE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

