Mental Health Recovery Board
Serving Warren & Clinton Counties

Private Hospital Request for Transfer to RPH/Summit

Request Date: _____

Client Name: _____

Private Hospital Information

Requesting Hospital Name: _____

Clinical Contact Person: _____ Treating Physician: _____

Contact Information:

Phone: _____ Email: _____ Fax:_____

For Private Hospital completion

Client Service Information

Date of Admission:

Insurance Name: _____ Behavioral Health Coverage: _____

If no insurance, explain why: _____

Diagnosis:

Psychological Testing Info: ☐ Yes ☐ No ☐ N/A
If yes, provide details:

Compliant with psychotropic medications: ☐ Yes ☐ No ☐ N/A
Psychotropic medication(s) prescribed at this time: ☐ None

Drug Name	Dosage	Frequency	Therapeutic Level
			☐ Yes ☐ No ☐ N/A
			☐ Yes ☐ No ☐ N/A
			☐ Yes ☐ No ☐ N/A
			☐ Yes ☐ No ☐ N/A
			☐ Yes ☐ No ☐ N/A

Number of previous admissions within the past year: _____

Month	Year	Facility	Length of Stay

Current Active Outpatient Treatment Provider Information:

Name: _____ Type of Treatment: _____

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Name: _____ Type of Treatment: _____
Other Information:

For MHRB Completion

MHRB Review by: _____
Date Clinical Data Received:_____
Review of Data Comments: _____
Date Notification sent to Provider:_____
Admission Approval Decision /Comments*: _____
Date of RPH/ Summit Contacted if admission approved: _____

**If request is denied, an explanation will accompany this sheet*

Signature of MHRB Staff: ________ **Date:** _____

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