Sharon Regional Health System

740 East State Street • Sharon, PA 16146
Telephone: 724-983-5644 • Fax: 724-983-3843

For all referrals: **The items listed on the left can be answered on this form or other forms containing the requested information. The items on the right need to be completed on this form. Please fax all forms to 724-983-3843. Thank you.**

Inpatient Admissions Referral Form

Referring Facility: _____ **Contact Person:** _____

Unit:_____ **Contact #** _____ **Referral Fax:**_____

Please complete and send the following information by fax to 724-983-3843

Patient Name:_____

Sex: _____**Age:** _____

Presenting Problem (Clinical):

_____
_____
_____
_____

Current and/or Previous Mental Health/Substance Abuse Treatment:

_____
_____
_____
_____

Current Medical Conditions and Medications (no IV medications permitted):

_____
_____
_____
_____

Current Psychiatric Medications:

_____
_____
_____
_____

Labs and Vitals:
BP:____P:_____R:____T:____BAC:_____

Will need CBC, BMP, UA, UDS, HCG, EKG

Current working psychiatric diagnosis if known (Axis I/Axis II):

_____
_____
_____

Reason for Choosing Sharon Regional:

- ☐ No child unit
- ☐ Facility is full
- ☐ Patient Choice
- ☐ Other _____

Voluntary 201____

Involuntary 302(PA Only)____

Is patient medically cleared and stable?

- ☐ **Yes**
- ☐ **No**

Name of treating MD (or designee):

_____

Contact Number:_____

Current Living Situation:_____

_____

What is the disposition plan for this patient?

_____
_____

Legal Issues, if any:

_____
_____

TO BE COMPLETED BY SRHS INPATIENT:
☐ ADMITTED: **Accepting Physician:**
_____

☐ NOT ADMITTED:
Clinician Consulted: _____

Time/Date: _____
Reason Declined:

_____

Referral Completed Date & Time: _____

Referral Completed by Signature/Title:

_____