Fit for Confinement Form

REQUESTOR INFORMATION: (To be filled in by Requestor)

Requesting Agency Name: _____

Name of Agency Representative: _____ Phone#_____

Type of Confinement Assessment Requested: ☐ **Medical** ☐ **Psychiatric**

PATIENT INFORMATION: (To be filled out by Hospital)

Patient Name _____ D.O.B _____

Current Medical Problems:_____

_____

Current Medications:

1._____3._____

2._____4._____

NAME OF PERSONAL PHYSICIAN:_____LAST SEEN:_____

PHYSICAL FINDINGS:

T_____P_____R_____B/P_____ALLERGIES_____

_____

_____

_____

EXAMINATION SUMMARY (Copies of labs, medications given, reports, needed appointments attached? _____)

Is patient **MEDICALLY** fit for confinement? ☐ YES ☐NO ☐ NOT EVALUATED

Is patient **PSYCHIATRICALLY** fit for confinement? ☐ YES ☐NO ☐ NOT EVALUATED

☐ Patient does not require inpatient medical treatment

☐ Patient does not require inpatient psychiatric treatment

☐ Outpatient Referral/Treatment Recommendation:

- ☐ Medical Treatment
- ☐ Psychiatric Treatment

Medications/treatment details:

_____

_____

_____

☐ Suicidal/Assault Precautions-**If checked, provide precaution details.** _____

_____

_____

FACILITY/DOCTOR INFORMATION

Facility Name: _____ Phone Number:_____

Physician Name (Printed):_____ Date/Time of Evaluation: _____

_____ _____

Physician, N.P. or P.A. Signature Date

Updated July 19, 2010