

Central State Hospital

**INITIAL RECOVERY PLAN (24-HR IRP)  
ADMISSION ORDERS**

<b>INDIVIDUAL'S NAME:</b>		<b>ID NUMBER:</b>	
<b>ADMISSION DATE:</b>		<b>DATE OF CONTINUOUS ADMISSION</b>	
<b>ADMIT TO UNIT:</b>		<b>SERVICE OF Dr.</b>	

**PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY**

I certify that inpatient psychiatric hospital admission is medically necessary, for either (1) treatment which could reasonably be expected to improve the individual's condition/symptomatology, or (2) diagnostic study.

**LEGAL STATUS:**

**ADMITTING DIAGNOSIS:**

Axis I	
Axis II	
Axis III	
Other Medical Conditions	
Axis IV	
Axis V	Current GAF:

**REASON(S) FOR ADMISSION:**

**TREATMENT GOALS:**

**INTERVENTIONS:**

The Individual's Identification

Name:

Avatar#:

<b>ACUTE MEDICAL CONDITIONS REQUIRING IMMEDIATE ATTENTION:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify below)
<input type="checkbox"/> none <input type="checkbox"/> choking/aspiration <input type="checkbox"/> fall <input type="checkbox"/> decubitus ulcer <input type="checkbox"/> nutrition	
<input type="checkbox"/> Other (specify): _____	
<b>POTENTIAL RISKS: Triggering Precautions/Policy</b>	
<b>PRELIMINARY DISCHARGE PLAN:</b>	

<b>ASSESSMENT:</b>
<b>Vital Signs:</b> <input type="checkbox"/> q Shift X 3 days, then q Day or <input type="checkbox"/> _____ (frequency)
<b>Pregnant:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Lactating:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>LAB/DIAGNOSTIC TESTS:</b>
<input type="checkbox"/> CBC <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> Urinalysis <input type="checkbox"/> Urine Drug Screen <input type="checkbox"/> RPR <input type="checkbox"/> TSH
<input type="checkbox"/> HCG (rec. for all females <50 y.o.) <input type="checkbox"/> Tegretol Level <input type="checkbox"/> Lithium Level <input type="checkbox"/> Depakote Level
<input type="checkbox"/> B12 <input type="checkbox"/> folate <input type="checkbox"/> amylase <input type="checkbox"/> lipase <input type="checkbox"/> CXR <input type="checkbox"/> EKG
<input type="checkbox"/> Metabolic Syndrome Protocol (Weight: on admission & q 1month. Waist circumference, Fasting glucose, and Fasting Lipid profile: on admission & q 3 months)
<input type="checkbox"/> CIWA Protocol <input type="checkbox"/> FSBS : _____ <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Outside Labs Reviewed

<b>INTERVENTIONS:</b>
<b>Diet:</b> <input type="checkbox"/> Regular Diet <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Intake/Output
<b>Activity:</b> <input type="checkbox"/> As tolerated <input type="checkbox"/> Restriction: _____ <input type="checkbox"/> Other (specify): _____
<b>Precautions:</b> <input type="checkbox"/> Elopement <input type="checkbox"/> Victimization <input type="checkbox"/> Suicide <input type="checkbox"/> Aggression <input type="checkbox"/> Other (specify): _____
<b>Level of Observation:</b> <input type="checkbox"/> Routine (30 minute checks) <input type="checkbox"/> Line of sight <input type="checkbox"/> 1:1 <input type="checkbox"/> More than 1:1 Specify reason (if other than routine observation): _____

Name:

Avatar#:

**Primary Active Treatment Need:**  
 Personal safety (Task orientation) **OR**  Recovery Education (specify type):

**Psychosocial Rehabilitation (PSR):**     On Unit     Off Unit

**Education:**     Orientation to Unit     Alcohol and Drug     Recovery skills     Health Maintenance  
 Other (specify):

**Outdoor Breaks:**     Permitted     Not permitted until re-evaluated and ordered by psychiatrist/physician

**LEPSI:**     Limited English Proficiency (specify language): \_\_\_\_\_     Hearing Impairment     Visual Impairment

**Consult for:**     Dietary     PT     OT     SLP     Other (specify):

**ALLERGIES:** \_\_\_\_\_

**MEDICATION RECONCILIATION COMPLETED**

**MEDICATION ORDER:**    **All medication orders are routine unless Stat or Urgent are indicated.**

Item #	Stop Date	Medication	Rationale
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
ID#

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
RN's Printed Name

\_\_\_\_\_  
RN's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

The Individual's Identification