Birch Tree Center
4730 Matterhorn Circle
Duluth, MN 55811
Phone: (218) 623-1800
Fax: (218) 623-1811

To Whom It May Concern:

Thank you for your interest in Birch Tree Center, a division of Thrive Behavioral Network, as a potential placement for mental health crisis stabilization services. It is our goal to provide quality person-centered care and enhance one's sense of safety, stability, and self-efficacy as we help folks return to a pre-crisis level of functioning. Our short-stay residential crisis stabilization program provides round-the-clock supervision, structure, and assistance from trained mental health staff. Those best served by our program include individuals who are unable to keep themselves safe while in the community, are at risk of being hospitalized due to their mental health symptoms, or need some additional support as they transition from a higher level of care back into the community.

Residential Crisis Services eligibility include:

- **Must be 18 years of age or older.**
- **Must have active health insurance or agree to private pay.** We encourage all referents to contact their insurance company to ensure Birch Tree Center is an in-network provider AND that their plan provides coverage for crisis services. Most plans authorize a 7-10 day stay.
- **Must be assessed as experiencing a mental health crisis or emergency that does not require hospitalization or detoxification but does require residential level of care.** This determination can be made by a member of a mental health crisis team, an emergency department, or a mental health professional.
- **Must be able to ambulate independently** - with or without the use of adaptive equipment.
- **Must be able to complete ADLs independently** – such as dressing, bathing, toileting, and feeding.

The following assessment collects demographic information needed to determine eligibility and asks questions that identify a referent's crisis and programming needs.

Upon receipt, staff will review the referral for appropriateness and reach out to the referral source with a determination. We accept referrals at the fax number and email address listed below, anytime, day or night. Please do not hesitate to contact us at (218) 623-1800 with any questions or concerns. Our team is happy to help you navigate the referral and admission process.

Sincerely,

Birch Tree Center Staff
[email] BTCReferral@thrivebn.com
[phone] (218) 623-1800
[fax] (218) 623-1811

GENERAL INFORMATION							
Name		**SSN**		**Date**			
Home Address							
City		**State**		**Zip Code**			
Mailing Address							
City		**State**		**Zip Code**			
DOB		**Age**		**Gender Identity**		**Sex**	❑ M ❑ F
Preferred Pronouns		**Race**		**Phone Number**			
Insurance	❑ Medical Assistance ❑ Commercial ❑ No Insurance/Private Pay **Insurance ID#**						

CURRENT PROVIDERS			
TYPE	**NAME**	**PHONE NUMBER**	**UPCOMING APPOINTMENTS**
Probation			
Guardian			
Social Worker			
Psychiatrist			
Therapist			
Doctor			
ARMHS			
Case Manager			
Group Home			
Emergency Contact			
Other			

Are you on commitment?	❑ Yes ❑ No	**Type**	

Mental Health Diagnosis

Nature of Current Crisis Symptoms

CURRENT FUNCTIONING									
Appearance	❑ Good	❑ Adequate	❑ Poor		**Sleep**	❑ Adequate	❑ Increased	❑ Decreased	
Speech	❑ Slow	❑ Pressured	❑ Normal	❑ Other:					
Oriented To	❑ Person	❑ Place	❑ Time		**Appetite**	❑ Adequate	❑ Increased	❑ Decreased	
Mood	❑ Appropriate	❑ Anxious	❑ Blunted	❑ Depressed					
	❑ Angry	❑ Labile	❑ Guarded	❑ Other:					
Ambulatory	❑ Yes	❑ No			**ADL Independent**	❑ Yes	❑ No		

SAFETY ASSESSMENT					
Suicidal Ideation	❑ Current	❑ Past	❑ None	Describe:	
Suicidal Plan	❑ Current	❑ Past	❑ None	Describe:	
Homicidal Ideation	❑ Current	❑ Past	❑ None	Describe:	
Homicidal Plan	❑ Current	❑ Past	❑ None	Describe:	

SELF-INJURY		
Previous Suicide Attempt	❑ No	❑ Yes – please describe below (ex: method, last attempt, etc.)
Non-Suicidal Self-Injury	❑ No	❑ Yes – please fill-out below (ex: method, last episode, etc.)
Hallucinations	❑ No	❑ Yes – please describe below (ex: auditory, visual, command, tactile, etc.)

SUBSTANCE USE					
Drug/Alcohol Use – If current, list all substances below	❑ Current	❑ Past	❑ None	(Describe below)	
History of Seizures due to Withdrawal	❑ No	❑ Yes – please describe below			
Is Detox Required?	❑ No	❑ Yes			

MEDICATIONS	
Medications – If yes, list medications below. Please bring a 10-day supply of medications in their original container to the facility.	
Is client currently taking medications as prescribed?	❑ Yes ❑ No

MEDICAL NEEDS			
List all medical needs and/or health issues below			
Diabetic	❑ Yes ❑ No	**Seizure Disorder**	❑ Yes ❑ No
List all allergies below			

GOALS OF TREATMENT
What is the current mental health goal for the client as it relates to Residential Crisis placement?

By signing this document, I attest the individual named above is experiencing a mental health crisis or emergency, and is in need of residential stabilization services in order to restore them to their pre-crisis level of functioning.

_____	_____	_____
Signature of Person Completing this Form	Name (please print)	Date

_____
Title/Credentials

If person completing this form is <u>not</u> a member of a mobile crisis team, a mental health professional or an emergency department, name and signature of the Mental Health Professional/Clinical Supervisor must also be included below.

_____	_____	_____
Signature	Name (please print)	Date

_____
Title/Credentials

CLIENT INFORMATION							
First Name		**MI**		**Last Name**			
Date of Birth		**Previous Name(s)**					
Address				**Phone Number**			
City		**State**		**Zip**			

AUTHORIZATION TO PERSONS/AGENCIES	
I hereby authorize	I hereby authorize PERSON/AGENCY releasing info:
▪ Thrive Behavioral Network I, LLC, ▪ Thrive Behavioral Network II, LLC, ▪ Thrive Behavioral Network III, LLC, ▪ Thrive Behavioral Network IV, LLC, ▪ Thrive Behavioral Network V, LLC, ▪ Grand Falls Maintenance Company	
Doing Business As	To release information to
	▪ Thrive Behavioral Network I, LLC, ▪ Thrive Behavioral Network II, LLC, ▪ Thrive Behavioral Network III, LLC, ▪ Thrive Behavioral Network IV, LLC, ▪ Thrive Behavioral Network V, LLC, ▪ Grand Falls Maintenance Company
To release information to PERSON/AGENCY receiving info:	
	Doing Business As

CHECK THE REASON(S) FOR RELEASING INFORMATION

- ❑ Treatment/care planning
- ❑ Service Coordination
- ❑ Review current care
- ❑ Payment for services
- ❑ Legal
- ❑ Health insurance application
- ❑ Application or appeal of application for Social Security Disability benefits
- ❑ Marketing
- ❑ Other:

SELECT INFORMATION FOR RELEASE

Release checked documents that were/are produced during these dates: _____ to _____

Health Care Records

- ❑ All Health Care Records (to include any information about you related to mental health evaluation and treatment,concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information)
- ❑ Specific health care records as indicated here:

Mental Health and/or Chemical Dependency Records:
(Chemical Dependency Records only if Special Consent indicated below, not to include psychotherapy notes)

- ❑ Functional Assessment
- ❑ Diagnostic Assessment
- ❑ LOCUS
- ❑ Treatment Plan
- ❑ Progress Notes
- ❑ Progress Reviews
- ❑ Discharge Summary
- ❑ Chemical Dependency Comprehensive Assessment/Summary

Residential, School, or Community Support and Social Services

- ❑ Assessments
- ❑ Community/Residential Support Plan
- ❑ Individualized Education Plan
- ❑ Progress notes
- ❑ Progress Reviews
- ❑ Discharge Summary

Information Requiring Special Consent by Law
(You must specifically request the following information in order for it to be released)

- ❑ Psychotherapy notes (if requesting these records, it must be a separate release where only this item is checked and no other documents)
- ❑ Chemical Dependency Assessment or Treatment Records (Records related to the specific assessment and treatment of alcohol or drug addictions)

Verbal Communication

- ❑ Permission is granted for verbal communication about my health/mental health care between parties identified above.
- ❑ Exchange selected documents only. No verbal communication.

Please understand and acknowledge that by signing this form:

You are requesting that confidential information be exchanged between the agencies or persons listed. You may stop this consent at any time by writing to any organization, facility, and/or professional listed above. You understand that health information released may include information about HIV/AIDS. You may inspect the records being released, or request a copy. You may be charged a fee for copies. You understand that once the information specified above is sent, it could be re-disclosed by the person that receives it and/or may no longer be protected by federal or state privacy laws. You understand that if the organizations listed are health care providers they will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this consent form. If you choose not to sign this form to release information to an insurance company, your failure to sign will not impact your treatment; but that you may not be able to get new or different insurance; and/or may not be able to get insurance payment for your care.

I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR,Parts 160 and 164, and cannot be disclosed without my written consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Choose the expiration date of this release:

- ❑ I understand that this consent will expire in one year from the date signed
- ❑ **OR**, I want this consent to expire on the following earlier date or event:

_____ _____

Client Date

_____ _____

Legal Representative Date

_____ _____

Staff Witness Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____