

State Hospital Triage Consultation and Expedited Admission (TCEA) Request

Please print. Please also be sure to provide ALL requested information.

Patient Information			
PATIENT'S LAST NAME	FIRST NAME	MIDDLE NAME	CAUSE NUMBER
INTERPRETER REQUIRED <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, WHAT LANGUAGE	DISABILITIES
BIRTHDATE	AGE	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	HOME PHONE NUMBER (WITH AREA CODE)
LAST KNOWN STREET ADDRESS		CITY	STATE ZIP CODE
MAILING ADDRESS: PO BOX		CITY	STATE ZIP CODE
GUARDIAN IF YES, NAME <input type="checkbox"/> Yes <input type="checkbox"/> No		GUARDIAN'S PHONE NUMBER (WITH AREA CODE)	
NAME OF ATTORNEY ASSIGNED		ATTORNEY'S PHONE NUMBER (WITH AREA CODE)	
Charge type: <input type="checkbox"/> Misdemeanor <input type="checkbox"/> Felony Service type: <input type="checkbox"/> Evaluation <input type="checkbox"/> Restoration			
DATE OF ARREST		DATE OF MOST RECENT COURT ORDER	
WHAT ABOUT THE INDIVIDUAL'S CONDITION, BEHAVIOR, OR PRESENTATION IS PROMPTING THIS REFERRAL?			
PLEASE DESCRIBE INTERVENTIONS / SUPPORTS THAT HAVE BEEN ATTEMPTED IN THIS FACILITY AND THE OUTCOMES			
RELEVANT RECENT HISTORY			

Does the individual current have a prescription for medications to treat mental health symptoms? Yes No

If no, has the individual expressed a willingness to take medications if prescribed?

Yes Not discussed No, unwilling

Is the individual currently taking medications to treat health symptoms? Yes No

If no, please describe efforts to administer medications:

Jail Information

REFERRING JAIL

REFERRING JAIL ADMINISTRATOR

PRIMARY CONTACT FOR THIS CASE

PRIMARY CONTACT'S PHONE NUMBER (WITH AREA CODE)

EMAIL ADDRESS(ES)

ADDITIONAL COMMENTS

Mental Health Provider

NAME OF AGENCY OR CLINICIAN CURRENTLY TREATING CLIENT

PRIMARY CONTACT'S NAME

TITLE / POSITION

PHONE NUMBER (WITH AREA CODE)

EMAIL ADDRESS(ES)

The above information is true to the best of my knowledge.

REFERRAL COMPLETED BY:

DATE OF REFERRAL

- Email this completed form to triageconsult@dshs.wa.gov. If you are unable to email, fax it to (360) 464-2225. If faxing, it is imperative that you provide all contact information requested on the form.
- At a minimum, your email must include the following:
 - A completed copy of this Triage Consultation and Expedited Admission (TCEA) Request.
 - A copy of the valid court order for admission to a state hospital.
 - Medical and Psychiatric Records from the jail facility.
 - Medication records for the last 72 hours.
 - Logs for the duration of the inmate's current stay at the jail facility detailing restraint and seclusion / special observation / administrative segregation / or disciplinary segregation.
 - If available, status of a court order for administration of involuntary medications. **An order for the administration of involuntary medications is not required for referral for expedited admission.**