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|  |  **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[ ]  Yes [ ]  No |  IF YES, WHAT LANGUAGE | DISABILITIES |
| BIRTHDATE | AGE | SEX[ ]  Male [ ]  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[ ]  Yes [ ]  No  | GUARDIAN’S PHONE NUMBER (WITH AREA CODE) |
| NAME OF ATTORNEY ASSIGNED | ATTORNEY’S PHONE NUMBER (WITH AREA CODE) |
| Charge type: [ ]  Misdemeanor [ ]  FelonyService type: [ ]  Evaluation [ ]  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 [ ]  NoIf 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 [ ]  NoIf 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.** |