Washington State Department of Social & Health Services
Transforming lives

State Hospital
Triage Consultation and Expedited Admission (TCEA) Request

Please print.

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 ☐ Yes ☐ No IF YES, NAME			GUARDIAN'S PHONE NUMBER (WITH AREA CODE)
NAME OF ATTORNEY ASSIGNED			ATTORNEY'S PHONE NUMBER (WITH AREA CODE)

☐ Felony charges individual awaiting: ☐ In-jail evaluation ☐ Inpatient evaluation ☐ Competency restoration

OR

☐ Misdemeanor charges individual awaiting:

☐ In-jail evaluation ☐ Inpatient evaluation ☐ Competency 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 THEOUTCOMES

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)

ADDITIONAL COMMENTS

Mental Health Provider

NAME OF AGENCY OR CLINICIAN CURRENTLY TREATING CLIENT

PRIMARY CONTACT'S NAME	TITLE / POSITION	PHONE NUMBER (WITH AREA CODE)

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

REFERRAL COMPLETED BY:	DATE OF REFERRAL

- This completed form should be emailed to triageconsult@dshs.wa.gov; or faxed to (360) 464-2225.
- This email and fan inbox is checked on a regular basis.
- 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 <u>not</u> required for referral for expedited admission.**