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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  Felony  Service 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  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.** | | | | | | | | | |