

Services Available

5. Emergency Services

a. Days of Operation: _____ Days a week (please specify: _____)

b. Hours of Operation: From: _____ a.m. To: _____ p.m.

c. Type of Service:

_____ Holding Beds _____ Adolescent Evaluation
_____ Geriatric Evaluation _____ Child Evaluation
_____ Adult Evaluation

d. Designated screening service: _____ Yes _____ No

If no, which designated screening services is utilized for your patients? _____

e. Staff Complement

Psychiatrist _____ F/T _____ P/T

Describe on-call capabilities/process _____

Clinicians

MSW (ACSW) _____ F/T _____ P/T

Ph.D. Psychologist _____ F/T _____ P/T

R.N _____ F/T _____ P/T

Other _____

6. Inpatient Psychiatric Services

a. Bed Complement

Adult Voluntary _____

Adult Involuntary _____

Adult Short Term Care Facility _____

Crisis Bed 23 hours _____

Child / Adolescent Beds _____

b. Available Inpatient Psychiatric Services

Dual Diagnosis _____ Medical Condition _____

Eating Disorder _____ Multiple Personality Disorder _____

Violent/Assaultive Pts. _____ Geriatric Pts. _____

Fire Setting Hx _____ Suicidal Pts. _____

Criminal Hx _____ ECT _____

Seclusion _____ Restraint _____

Access for Persons
with a Disability _____

c. Psychiatric Staff

Medical Director F/T _____ P/T _____

Adult Psychiatrist F/T _____ P/T _____

Child Director F/T _____ P/T _____

Describe on-call capabilities/process: _____

d. Inpatient Program Capabilities

Medical History & Physical _____ EKG _____

Psychological Services _____ Laboratory Services _____

EEG _____ Pharmacy Services _____

Radiology _____ Psychiatric Services _____

Nursing Assessment _____ Activities Assessment _____

Social Services Assessment _____

7. Inpatient Chemical Dependency/Detox Services

a. Bed Complement

Geriatric_____ Adult_____ Adolescent_____ Child_____

b. Specialty Needs/Services

Dual Diagnosis_____ Seclusion_____

Medical Condition_____ Restraint_____

Violent Patients_____ Suicidal Patients_____

c. Staff Complement

Medical Director F/T _____ P/T _____

Adult Psychiatrist F/T _____ P/T _____

Child Director F/T _____ P/T _____

Describe on-call capabilities/process:_____

8. Structured Intensive Outpatient Services

Type: _____ Chemical Dependency _____ Mental Health

a. Medical Director _____ F/T _____ P/T

Other Staff_____

b. Program Elements

Days of Operation: _____ Mon. _____ Tues. _____ Wed. _____ Thurs.

_____ Fri. _____ Sat. _____ Sun.

Hours of Operation: From:_____ am/pm To:_____ am/pm

Individual Therapy____ Family Therapy_____ Group Therapy_____

Medical Services_____ Emergency Medical Services_____

Medical Detox Services_____ Relapse Prevention_____

Aftercare_____ General Health Care_____

Interpersonal Relationships_____ Antabuse/Naltrexone Monitoring_____

9. Outpatient Psychiatric Services

a. Days of Operation:

_____ Mon. _____ Tues. _____ Wed. _____ Thurs.
_____ Fri. _____ Sat. _____ Sun.

b. Hours of Operation:

From: _____ am/pm To: _____ am/pm

c. Type of Service:

Initial Evaluation _____	Emergency Appt. (same day) _____
Individual _____	Group _____
Family _____	Marital/Couple _____
Parenting Skills _____	Medication Clinic _____

d. Staff Complement

Psychiatrist _____ F/T _____ P/T

Describe on-call capabilities/process _____

Clinicians

MSW (ACSW) _____ F/T _____ P/T

Ph.D. Psychologist _____ F/T _____ P/T

R.N _____ F/T _____ P/T

e. Waiting Time for Appointment:

Number of Days _____

f. Ages Served: From _____

To _____