

CONNECTICUT VALLEY HOSPITAL
Phone: (860) 262-5000
P.O. Box 351 SILVER STREET, MIDDLETOWN, CT 06457

PATIENT DATA FOR EVALUATION/ADMISSION TO ANOTHER HOSPITAL

INSTRUCTIONS: *To be completed by licensed physician on staff from Connecticut Valley Hospital.*

_____ is being referred from Unit _____ to _____
(Patient Name) (Name of Hospital)
for the following medical or surgical conditions: _____

1. Psychiatric Diagnosis: _____

 - a. Escape Risk _____
 - b. Danger to Self _____
 - c. Danger to Others _____
2. Patient's Legal Status: _____
 - a. Voluntary _____
 - b. Involuntary _____ Type of Commitment _____
3. Patient Directives:
 - a. Do Not Resuscitate? ☐ No ☐ Yes If yes, attach Transfer of "Do Not Resuscitate" Order form
 - b. Advance Directive? ☐ No ☐ Yes If yes, attach Advance Directive Document/Form
 - c. Anatomical Donation? ☐ No ☐ Yes If yes, attach Organ Donation Document/Form or Copy of Patient's Driver's License.
4. Ability to Give Informed Consent:
 - a. This patient has been declared legally incompetent by the Probate Court and has a conservator of person. ☐ No ☐ Yes
 - b. Patient is considered psychologically incapable of giving informed consent. ☐ No ☐ Yes

If Yes to 4a or 4b, permission is to be obtained from one of the following:

- a. Next of Kin _____
 - b. Guardian/Conservator _____
 - c. Physician appointed by the Judge of Probate _____
 - d. Chief Executive Officer, for emergency care _____
5. Connecticut Valley Hospital has notified:
Next of Kin or Guardian (Name) _____
Relationship to Patient _____
Address _____ Phone _____

Signature of Physician Completing Form Date _____ Time _____ AM/PM

Name Printed: _____ Connecticut License Number: _____

Distribution: **ORIGINAL** - Hospital **COPY** - Chart (*Physical Health Section*)

NURSING: please complete Nursing handoff