HIGHPOINT HEALTH

Request Form: Escalation of Psychiatric Care

Patient:_____ DOB: _____ Facility: _____

The above-named Patient is enrolled in services with HighPoint Psychiatry, but he/she is not scheduled for a psychiatric visit at this time. I have observed an acute change in the Patient's psychiatric functioning that leads me to the professional opinion that he/she requires immediate psychiatric intervention. Any delay in such services could result in:

- ☐ Complications Related to Newly Prescribed Medications
- ☐ Self-Injurious Behaviors
- ☐ Assaultive Behaviors
- ☐ Psychiatric Hospitalization
- ☐ Undue Mental or Emotional Distress

Check Any Items that Apply

My professional judgment is based upon the following:

- ☐ Increased Depressive Symptomatology
- ☐ Suicidal Statements or Gestures
- ☐ Verbal Aggression or Threats
- ☐ Acute Anxiety or Agitation
- ☐ Paranoia
- ☐ Hallucinations
- ☐ Delirium
- ☐ Negative Reaction to a New Psychiatric Medication
- ☐ Other:

Check Any Items that Apply

I attest that the information provided on this form is an accurate representation of my professional observations and judgment.

_____	_____	_____
Name & Title*	Signature	Date

*This form may only be completed by the Director of Nursing, Assistant Director of Nursing, Medical Director, or RN.

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