Laureate
Senior Behavioral Health
A part of Saint Francis Health System

Documentation Requirements for Admission:

- ☐ Face Sheet / Demographic Sheet
  - Brief overview of the patient's medical history.
  - If from a nursing home or hospital, attach the physician's progress note or relevant clinical summary.
- ☐ Behavioral / Progress Notes (Last 72 Hours)
  - Clear clinical picture of current and recent behaviors (e.g., suicidal ideation, hallucinations, violent behaviors, etc.).
  - Description of interventions already tried and the patient's response.
- ☐ Updated Medication List
  - Include the most recent medications with dates/times of last administration.
  - For injectables, specify the last administration date.
  - If transferring from another hospital, provide both home and current hospital medication lists.
- ☐ Long-Term Interventions (if applicable)
  - Document any ongoing needs (e.g., oxygen, Foley catheters, etc.).
- ☐ Legal Documentation
  - Durable Power of Attorney (DPOA) or Guardianship paperwork (if applicable).
  - Advance Directives (if applicable).
  - Do Not Resuscitate (DNR) orders (if applicable).
- ☐ Recent Lab Results (Last 2 Weeks)
  - Include any labs that may impact immediate treatment or the admission decision.
- ☐ 3rd Party Statement / LMHP Form (if applicable)
  - If no POA/Guardian is available and the patient cannot consent, attach a completed 3rd party statement or LMHP form.