Single Bed Certification Form

Fax requests to:
Western State Hospital FAX# 253-756-2873

Requesting RSN: ☐GHRSN ☐ KCRSN ☐ NSMHA ☐ PRSN ☐ OPRSN ☐ SWBHA ☐ TMRSN ☐ TRSN ☐ Facility	☐ Initial request ☐ Extension request

Name and title of RSN requester:

Requester Fax #:	Requester Phone #:

The requestor attests that the facility that is the site of the proposed single bed certification confirms that it is willing to provide directly, or by direct arrangement with other public or private agencies, treatment to the consumer suffering from a mental disorder for whom the single bed certification is sought.

Facility:	Accepted by:	Accepter's Phone #:

Patient name (first, last, M.I.):

DOB:	SSN:(if avail.)	CID: (ProviderOne or CIS.)
Gender: ☐M ☐F	Legal status at time of request: ☐ 72 Hour Hold ☐ 14 Day Commitment ☐ LRA Revocation ☐ 90 Day Commitment ☐ 180 Day Commitment	

Criteria for Request:

☐ The consumer requires services that are not available at a certified evaluation and treatment facility or a state psychiatric hospital. Describe the services that are not available**.**

_____

_____

_____

☐ The consumer can receive appropriate evaluation and treatment in one of the following:

- ☐ A hospital with a psychiatric unit
- ☐ A hospital that can provide psychiatric services
- ☐ A psychiatric hospital

☐ The consumer can receive appropriate evaluation and treatment in a residential treatment facility, as defined under chapter 246-337 WAC and the certification will be only to such a residential facility.

The RTF is a certified E&T ☐ Y ☐ N (Requests for RTFs that are not an E&T must be accompanied with an attachment detailing how the placement will meet the consumer's evaluation and treatment needs.)

☐ The consumer is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care, consistent with the consumer's individual treatment needs.

If consumer is under 18 years of age, is this request for certification on an adult unit? ☐ Y ☐ N

This portion of form to be completed by state hospital staff

Certification approved by:	Title:
Date approved:	Time approved:

THIS CERTIFICATION EXPIRES 30 DAYS FROM DATE OF APPROVAL OR DECEMBER 26, 2014 WHICHEVER COMES FIRST.

WSH Switchboard: 253-582-8900