



McLaren Print System Order

Order No: 82091 Order Date: 2024-01-04 User: Brooke Pearson Phone: 2316271370

Ship Location: McLaren Cheboygan- BHU Attn: Brooke Pearson

748 South Main St Cheboygan, Mi 49721

Forms

Quantity: 500

Paragon Dept No: 30462 Dept Name: BHU Company Number: 410

Order Total Price: 24.90

Item Number: MHCC-688-MNM

Item Description: Behavioral Health Screen

Revision Date: 08/2023 Print: 2 sided black and white

Paper: 20# White Text

Size: 8.5 x 11 Fold: Finish: None Drill: 2 Hole Top

Poster:

Misc Info: DS, Black



BEHAVIORAL HEALTH SCREEN

Approval Time: Admitting Diagnosis: Admit to: Inpatient BHU PHP Geriatric BHU Admit to Dr.:	arted: Time Screen Ended: Time Faxes Received: ped & Time(a) Paged: Involuntary	Date:		IH Staff/Time of						
Psychiatrist Paged & Time(s) Paged: Voluntary	Involuntary	Patient Name:				DOB:	Age:	_ M	ale	☐ Fen
Voluntary Involuntary Petition 1st Cert. Deferred Court Order	Involuntary	Time Screen Starts	ed:	Time Screen	Ended:		Time Faxes I	Received:		
Approval Time: Admitting Diagnosis: Admitto: Inpatient BHU	Admitting Diagnosis: Inpatient BHU	Psychiatrist Paged	&Time(s) Paged:							
Admit to: Inpatient BHU PHP Geriatric BHU Admit to Dr.: Patient Address: Patient's Current Location: ER In Other Facility Name: Phone #: CMH Screen CMH Screen Soc. Sec. #: BH Staff Completing Screen Marital Status: Veteran: Yes No Name of Caller/Company PCP: Contacted: Yes No Caller's Phone #: Psychiatrist: Patient's Legal Status: Previous In-pt. (Where / When): Out-pt. Treatment: Therapist Guardian Name: Case Manager: (1) Primary Insurance Phone #: (2) Secondary Insurance Phone #: Card #: (1) Subscriber's Name / DOB: # of Days Authorized: (2) Subscriber's Name / DOB: Contact Person/Phone #: Relationship to Patient: Authorization #: Presenting Problem:	Inpatient BHU	□ Voluntary	☐ Involuntary	☐ Petition		1 ^{st.} Cert.	□ Deferred	☐ Court C)rder	
Patient Address: Patient's Current Location: Defined in the property of the p	Patient's Current Location:	Approval Time:		Admitting	Diagnosi	s:				
Other Facility Name: Phone #: CMH Screen CMH Screen Soc. Sec. #: BH Staff Completing Screen Marital Status: Veteran: Yes No Name of Caller/Company PCP: Contacted: Yes No Caller's Phone #: Psychiatrist: Patient's Legal Status: Previous In-pt. (Where / When): Out-pt. Treatment: Therapist Guardian Name: Phone #: (1) Primary Insurance (2) Secondary Insurance Phone #: Card #: Card #: Card #: Card #: Card #: Card #: Contact Person/Phone #: Relationship to Patient: Authorization #: Presenting Problem:	Other Facility Name: CMH Screen	Admit to:	atient BHU 🗆 PH	P Geriatric	вни 🗆	Admit to D	r:			
Soc. Sec. #: Marital Status: Veteran: Yes No Name of Caller/Company PCP: Contacted: Yes No Caller's Phone #: Psychiatrist: Previous In-pt. (Where/When): Therapist Case Manager: (1) Primary Insurance Phone #: Card #: (1) Subscriber's Name/DOB: (2) Subscriber's Name/DOB: Relationship to Patient: Pessenting Problem:	BH Staff Completing Screen Veteran:	Patient Address:						□ER	□ Me	ed. Floo
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Previous In-pt. (Where /When): Therapist Case Manager: (1) Primary Insurance Phone #: Card #: (1) Subscriber's Name /DOB: (2) Subscriber's Name /DOB: Relationship to Patient: Card #: Out-pt. Treatment: Guardian Name: Phone #: (2) Secondary Insurance Phone #: Card #: Card #: Card #: Card #: # of Days Authorized: Contact Person/Phone #: Authorization #: Presenting Problem:	Where / When): Out-pt. Treatment: Guardian Name: Phone #: (2) Secondary Insurance Phone #: Card #: Name / DOB: Name / DOB: Patient: Authorization #:	PCP:	Co	ontacted: □Yes	□No	Caller's P	hone #:			
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Case Manager: (1) Primary Insurance Phone #: (2) Secondary Insurance Phone #: Card #: Card #: (1) Subscriber's Name / DOB: (2) Subscriber's Name / DOB: (2) Subscriber's Name / DOB: (3) Subscriber's Name / DOB: (4) Subscriber's Name / DOB: (5) Subscriber's Name / DOB: (6) Subscriber's Name / DOB: (7) Subscriber's Name / DOB: (8) Authorization #: Presenting Problem:	Phone #: (2) Secondary Insurance Phone #: Card #: Name /DOB: # of Days Authorized: Name /DOB: Contact Person/Phone #: Patient: Authorization #:	Previous In-pt. (Wh	ere/When):			Out-pt. Tr	eatment:			
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