Single Bed Certification Form WAC 388-865-0526

Fax requests to:
Eastern State Hospital FAX# 509-565-4616

Requesting RSN: ☐CDRSN ☐GCBH ☐SCRSN ☐Facility	☐ Initial request ☐ Extension request

Name and title of RSN requester:

Requester Fax #:	Requester Phone #:
Date Requested:	Time Requested:

The site of the proposed single bed certification confirms that it is willing and able to provide directly, or by direct arrangement with other public or private agencies, timely and appropriate mental health treatment to the consumer suffering from a mental disorder for whom the single bed certification is sought. The single bed certification will apply only to that facility.

Facility:	Accepted by:	Accepter's Phone #:

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

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

Criteria for Request – check one box:

☐ The consumer requires medical 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 mental health treatment in one of the following:

- ☐ A hospital with a psychiatric unit
- ☐ A hospital that is willing and able to provide timely and appropriate mental health treatment
- ☐ A psychiatric hospital

☐ The consumer can receive appropriate evaluation and treatment in a residential treatment facility, as defined under chapter 246-337 WAC.

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

ESH Switchboard: 509-565-4644