http://itscportal/sites/DMHMRSAS/newsclips/DMHMRSAS%20Graphics%20Library/DBHDS%20Logo/DBHDS_Logo_Cropped-SM.jpg

**DAP SECURE MEMORY CARE JUSTIFICATION**

## Instructions:

With the assistance of the state hospital social worker, complete to determine patient’s need for secure memory care.

**Patient Name:** Click or tap here to enter text.

|  |  |
| --- | --- |
| **SECURE MEMORY CARE NEEDS** |  |
| Has this individual been diagnosed with Major Neurocognitive Disorder (dementia)? If yes, please list specific diagnosis: Click or tap here to enter text. | **Choose an item.** |
| What is this individual’s level of mobility? Does this individual require equipment in order to ambulate? If yes, explain Click or tap here to enter text. | **Choose an item.** |
| Has this individual engaged in exit-seeking behaviors on a consistent basis while hospitalized? If yes, explain Click or tap here to enter text. | **Choose an item.** |
| Can the individual be supported safely to a less restrictive setting with a monitoring device such as project lifesaver or wander guard? Click or tap here to enter text. | **Choose an item.** |
| Is this individual currently formally identified by the state hospital as an elopement risk?Click or tap here to enter text. | **Choose an item.** |
| Please provide a justification as to why a secure (locked) facility is the least restrictive setting appropriate for this individual’s discharge from the state hospital: Click or tap here to enter text. | **Choose an item.** |

CSB DAP Coordinator Signature ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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