

Behavioral Health CareConnection®
Data Collection Form: Inpatient (Tier 4)

Member Name: _____

Member ID: _____

HIGH INTENSITY SERVICE REVIEW (PARTIAL, INPT., PRTF, CSU)

Is this a sex offender program? Yes No

Admitting Physician: _____

Admission Status: Urgent Elective

Time of Admission: _____ AM PM

Beginning date of symptoms warranting this level of care: _____

RETROSPECTIVE REVIEW SECTION (complete only if retrospective review requested)

Reason for Retrospective Review: Unknown eligibility at time of admission After hours/Weekend admission
 Retroactive Disenrollment from MCO

ADMISSION PRECAUTIONS / PSYCHIATRIC INTERVENTIONS: (check all that apply)

- Suicidal Precautions
- Intermittent Physical Restraint
- Locked Unit
- Elopement Precautions
- Medication Adjustment
- Critical Incidents

- Homicidal Precautions
- Assault Precautions
- Observation at least every 30 min.
- ECT (Initial)
- Group Therapy
- Physical Restraint(once)

- Seclusion Precautions
- Sex Offender Precautions
- ECT (Maintenance)
- Behavioral Intervention

CLINICAL INFORMATION SUPPORTING ADMISSION

Any chronic medical conditions not included earlier?
 Yes No

* If yes, please list

Additional Diagnosis Code 1
Additional Diagnosis Code 2
Additional Diagnosis Code 3
Additional Diagnosis Code 4

Do current psychiatric symptoms impair diagnosis and/or treatment interventions for acute, serious medical condition(s) listed above resulting in imminent risk of acute medical deterioration? Yes No

Abnormal Laboratory Findings? * Yes No

* If yes, please describe:

Family involvement in Treatment: * Yes No

* If yes, please indicate relation & method of involment:

Relation: Spouse/Partner Parent Guardian Foster Parents
 Sibling Child Other, explain _____

Method of involvement: Family Therapy Visitation Telephone

Identify Level of Psychiatrist Involvement: _____ (1-9) times per (day, week)

Treatment Objectives: (check one)

- Return to pre-admission functioning
- Relieve acute symptoms, return to baseline functioning
- Relieve acute symptoms and stabilize for further treatment options
- Maintain current status/prevent deterioration

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CLINICAL INFORMATION SUPPORTING ADMISSION Continued..

Level of Care Checklist (check all that apply)

- Failure to make sufficient progress or gains from outpatient services
- No attempted outpatient services but current symptom severity & functional impairments require more intensive treatment
- Intensive outpatient programs not available
- Crisis Stabilization Unit is not sufficient or available
- Requires step down from high intensity service but is not ready for traditional outpatient
- At risk for regression to point of requiring more intensive intervention or residential care
- Risk of harm to self, others and/or property that cannot be managed at lower level of care
- Unable to care for physical or medical needs and requires intensive level of care

Initial Discharge Plan: (check one)

- Return to previous environment with outpatient services
- Modify environment with outpatient services
- Intensive Outpatient
- Partial Hospitalization Program
- Need a higher level of care
- PRTF
- Residential Care
- Assertive Community Treatment

CONTINUING STAY INFORMATION

Treatment Progress, Engagement and Methods

(select one)

- Symptom decline since admission, pending discharge
- Existing symptom decline although new symptoms emerging
- Symptoms remain at intensity of admission
- Potential for serious regression and readmission as seen by failed treatment passes, individual high risk for community integration
- Demonstrating progress, unit privileges increasing or therapeutic passes occurring without difficulty
- New symptoms and functional impairments have emerged requiring continued services at this level of care

Treatment Methods: (check all that apply)

- Group Therapy
- Individual therapy
- Skill Building/Behavior Management
- Play/Art/Music Therapy
- Supportive Services
- Other, please describe _____

Does individual actively participate and display interest in achieving treatment goals? Yes No

Are therapeutic passes utilized? * Yes No Program does not offer passes

*If yes, # of passes since admission: _____

Is there daily compliance with recommended treatment services? Yes No, # of consecutive days noncompliant: _____

Is there daily compliance with medications? Yes No* *If No, # of consecutive days noncompliant: _____

Family Therapy occurring? Yes* No *If Yes, # of times per week? ____ (1-5) times per week

Family Members Participating: Spouse/Partner Parent Sibling Child Other

Method of involvement: In-person Phone

Medication Administration

Indicate medication changes or adjustments to initial regimen:

	Medication	Current Dosage	Status/Adjustments*	Amount Modified
Anti-Depressant:				
Anti-Cholinergics:				
Mood Stabilizer:				
Anti Psychotic:				
Anti Anxiety:				
Anti Convulsant:				
Hypnotic:				
Stimulant:				
Other:				

*Status/Adjustments = Increase, Decrease, Discontinue, No Change

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Laboratory Findings

Subsequent or continued abnormal laboratory results not reported during on initial request? Yes No

If yes, please describe:

PRECAUTIONS / PSYCHIATRIC INTERVENTIONS: (check all that apply)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Suicidal Precautions | <input type="checkbox"/> Medication Adjustments | <input type="checkbox"/> Observation at least every 30 min. | <input type="checkbox"/> Seclusion/Isolation |
| <input type="checkbox"/> Intermittent Restraints* | <input type="checkbox"/> Critical Incidents** | <input type="checkbox"/> ECT (Initial) | <input type="checkbox"/> Sex Offender Precautions |
| <input type="checkbox"/> Locked Unit | <input type="checkbox"/> Homicidal Precautions | <input type="checkbox"/> Group Therapy | <input type="checkbox"/> ECT (Maintenance) |
| <input type="checkbox"/> Elopement Precautions | <input type="checkbox"/> Assault Precautions | <input type="checkbox"/> Physical Restraint(once) | <input type="checkbox"/> Behavioral Interventions |

*If Intermittent Restraints is checked, specify number and type:

Number: _____ Type: _____

*If Critical Incidents is checked, specify number and type:

Number: _____ Type: _____

Explain continued and new precautions, specific to frequency, number and type:

Describe Discharge plan:

- | | |
|--|--|
| <input type="checkbox"/> Return to previous environment with outpatient services | <input type="checkbox"/> Intensive Outpatient |
| <input type="checkbox"/> Modify environment with outpatient services | <input type="checkbox"/> Residential Care |
| <input type="checkbox"/> Partial Hospitalization Program | <input type="checkbox"/> PRTF |
| <input type="checkbox"/> Need a higher level of care | <input type="checkbox"/> Assertive Community Treatment |