

Behavioral health psychiatric residential treatment facilities initial review form

Please fax this form to 1-800-505-1193 before admission.

Today's date:		
Contact information		
Member name:	Member ID or reference #:	Member DOB:
Member address:		Member phone #:
For child/adolescent, name of parent/guardian:		Primary spoken language:
Facility/provider submitting clinical review:		Requested PMIC (if applicable):
Requested PMIC admit date:		Member's current location:
Can member return to current location (if applicable)?		
For members with home- and community-based services waivers, please include support coordinator/targeted case manager information.		
EPSDT support coordinator name:	EPSDT support coordinator phone:	EPSDT support coordinator fax:
Clinician or doctor who can provide PMIC review and signed CON (if needed):		Clinician or doctor's phone number:
Name of person completing form:		Phone # of person completing form:
Diagnosis: psychiatric, chemical dependency and medical		

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Precipitant to admission: Be specific — Why is PMIC level of care needed?

Clearly document behaviors occurring in the previous three months.

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Barriers to treatment progress (if admitted)

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Current legal issues

Is member in a juvenile detention center? Has the member had an adjudication hearing — If so, what is the date? Is the member in jail?

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Substance abuse or dependence: current urinary analysis/lab results

Previous treatment

Include provider name, facility name, medications, specific treatment/levels of care and adherence. Please attach current psychological treatment. Be specific: previous inpatient, PMIC, group care, PHP, IOP, BHIS, therapy (individual and family), medication management, intensive community supports, etc. — What are the dates of service and provider names?

Current treatment plan
Medications:
As-needed medications administered:
Other treatment and/or interventions planned (including when family therapy is planned):
Support system
Include coordination activities with case managers, family, community agencies, etc. If case is open with another agency, name the agency, phone number and case number.

Social history

Include school, family and community, behavioral issues, developmental issues, and IEP.

Initial discharge plan

List name and number of discharge planner, name of providers, addresses, and phone numbers.

Days requested for this review:

Expected length of stay from today:

Submitted by:

Phone number: