# Behavioral health psychiatric residential treatment facilities initial review form

**Please fax this form to 1-877-434-7578 before admission.**

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|---|---|---|
| Today's date: | | |
| **Contact information** | | |
| Member name: | Member ID or reference number: | Member date of birth: |
| Member address: | | Member phone number: |
| For child/adolescent, name of parent/guardian: | | Primary spoken language: |
| Facility/provider submitting clinical review: | | Requested psychiatric residential treatment facility (PRTF) (if applicable): |
| Requested PRTF admit date: | | Member's current location: |
| Can member return to current location? (if applicable): | | |

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| **For members with Home and Community-Based Services waiver - please include support/service coordinator/targeted case manager information** | | |
| Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Support Coordinator name: | EPSDT Support Coordinator phone: | EPSDT Support Coordinator fax: |

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| Clinician or doctor who can provide PRTF precertification review (if needed): | Clinician or doctor's phone number: |
| Person completing form: | Phone number of person completing form: |
| **Diagnosis (psychiatric, chemical dependency and medical)** | |
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**Precipitant to admission**

Be specific. Why is the PRTF level of care needed?

**(Clearly document behaviors occurring in the previous 3 months)**

**Barriers to treatment progress (if admitted)**

| Current legal issues |
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| **(Is member in a juvenile detention center? Has member had an adjudication hearing? If so, what is the date? Is member in jail?)** |
| **Substance abuse or dependence**<br>Current urinary analysis/lab results |
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**Previous treatment**

Include provider name, facility name, medications, specific treatment/levels of care and adherence.

**Please attach current psychological**

**(Please be specific: inpatient, rehab, partial hospitalization program, inpatient outpatient program, inpatient family intervention, community support individual, intensive community supports, etc. What are the dates of service and provider names?)**

**Current treatment plan**

**Standing medications:**

**As-needed (PRN) medications administered (not ordered):**

**Other treatment and/or interventions planned (including when family therapy is planned):**

| Support system |
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| **(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**<br>Include school, family and community, behavioral issues, developmental issues, IEP |
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| **Initial discharge plan**<br>List name and phone number of discharge planner. List names of providers, addresses and phone numbers. | |
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| | |
| **Days requested for this review:** | |
| **Expected length of stay from today:** | |
| **Submitted by:** | **Phone number:** |