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	☐ Homicidal Precautions	☐ Seclusion Precautions
☐ Intermittent Physical Restraint	☐ Assault Precautions	☐ Sex Offender Precautions
☐ Locked Unit	☐ Observation at least every 30 min.	☐ ECT (Maintenance)
☐ Elopement Precautions	☐ ECT (Initial)	☐ Behavioral Intervention
☐ Medication Adjustment	☐ Group Therapy	
☐ Critical Incidents	☐ Physical Restraint(once)	

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 Hosptialization 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)

☐ Suicidal Precautions	☐ Medication Adjustments	☐ Observation at least every 30 min.	☐ Seclusion/Isolation
☐ Intermittent Restraints*	☐ Critical Incidents**	☐ ECT (Initial)	☐ Sex Offender Precautions
☐ Locked Unit	☐ Homicidal Precautions	☐ Group Therapy	☐ ECT (Maintenance)
☐ Elopement Precautions	☐ Assault Precautions	☐ Physical Restraint(once)	☐ 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:

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