INPATIENT TREATMENT REPORT (ITR) - Page One of Two

Requested Start Date for this Authorization ____/____/____

Services: □Inpatient Acute □RTC □RTU □RTC/Sex Offenders
Transfer Request: □ acute to residential □ residential to residential

Type of Review: □Prospective □Concurrent □Discharge □Retrospective: Beneficiary discharged? □Yes □No
Precipitating Event: _____
CON Completed □Yes □ No □ NA Date Signed: _____
Beneficiary's Current Location: □ER □Jail/Detention □Facility □ Provider's Office □Home/Community

Demographics:
Beneficiary's Name _____Date of Birth: _____
Beneficiary's Medicaid ID#: _____ Tel #: _____
Guardian Name: _____Beneficiary's Address: _____
City: _____State: _____
Facility: _____ Medicaid ID#_____
Fac. Address/City/St: _____
Attending Provider: _____ Tel #:_____
UR Name: _____
UR Phone #: _____ UR Fax #: _____

DSM-IV Diagnosis:
Is the primary focus of treatment a developmental disorder or a pervasive developmental disorder? □Yes □No
Axis I 1) _____ 2) _____
Axis II: 1) _____ 2) _____
Axis III: 1) _____ 2) _____
Axis IV: _____
Axis V: Current GAF: _____ Highest GAF prev. year: _____

Current Risks: *Risk Level Scale: 0=none, 1-mild, ideation only; 2=moderate, ideation with EITHER plan or history of attempts; 3=severe, ideation AND plan, with either intent or means; na=not assessed. Circle risk level for each category and check all boxes that apply:*

Risk to Self (SI): 0 1 2 3 na with □ideation □intent □plan □means
Risk to Others (HI): 0 1 2 3 na with □ideation □intent □plan □means
Current serious attempts: □ Yes □ No Circle SI HI
Prior serious attempts: □ Yes □ No Circle SI HI
Prior serious gestures: □ Yes □ No Circle SI HI
Date of the most recent attempt or gesture: ____/____/____

Current Impairments: Scale 0=none, 1=mild, 2=moderate, 3=severe, na=not assessed
0 1 2 3 na Mood Disturbance (Depression or mania)
0 1 2 3 na Anxiety
0 1 2 3 na Psychosis
0 1 2 3 na Thinking/Cognition/Memory
0 1 2 3 na Impulsive/Reckless/Aggressive
0 1 2 3 na Activities of Daily Living
0 1 2 3 na Weight Change Assoc. w/Behav Dx →□Gain □ Loss □ na of _____ pounds in last three months
0 1 2 3 na Medical/Physical Condition(s)
0 1 2 3 na Substance Abuse/Dependent
0 1 2 3 na Job/School Performance
0 1 2 3 na Social/Marital/Family Problems
0 1 2 3 na Legal
Current weight - _____ lbs □na
Height - _____ft. _____ in. □na

Mental Health/Psychiatric History: *(Please check all that apply)* □ None □ Unknown

□ Outpatient. *If "Outpatient" is checked, please indicate:*
Outcome: □ Unknown □ Improved □ No Change □ Worse
Treatment compliance (non-med): □ Unknown □ Poor □ Fair □ Good
□ Day Treatment/Rehab day. *If "day treatment/rehab day" is checked, please indicate:*
Outcome: □ Unknown □ Improved □ No Change □ Worse
Treatment compliance (non-med): □ Unknown □ Poor □ Fair □ Good
□ Inpatient/Residential/Group Home: *If "Inpatient/Residential" is checked, please indicate:*
Outcome: □ Unknown □ Improved □ No Change □ Worse
Treatment compliance (non-med): □ Unknown □ Poor □ Fair □ Good
Number of psychiatric hospitalizations in the past 12 months:

Substance Abuse History: *(Please check all that apply)* *Yes* □ None □ Unknown
Describe: _____

Other History:
Is beneficiary in DYS custody? □ Yes □ No
Is beneficiary in DCFS custody? □ Yes □ No
Criminal/juvenile justice involvement in the last 12 months? □ Yes □ No
Currently on probation: □ Yes □ No
Does beneficiary have a current FINS petition? □ Yes □ No
History of sexually inappropriate/aggressive behavior? □ Yes □ No
History of fire setting in the last 12 mos? □ Yes □ No
Active gang involvement in the last 12 mos? □ Yes □ No
DCFS involvement in the last 12 mos? □ Yes □ No
Victim of sexual or physical abuse? □ Yes □ No

Beneficiary's Name: _____ **Beneficiary's ID#**_____
Current Psychotropic Medications: □None *Dose* *Freq.* *Usually compliant?*

			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No

Treatment Request: Admit Date: ____/____/____
Number of additional days requested: _____
Dates patient absent without permission: _____

Has the physician signed the treatment plan? □Yes □No
Date of Family Therapy Appointment: ___/___/___

□ Involuntary □ Court Ordered □ Fixed Length Program (Specify length: _____)
Frequency of program = _____ per _____
Reason for Continued Stay: □Remains symptomatic □ Conduct family therapy
□ Stabilize medications □Has not achieved treatment goals □ Finalize dischg. Plan
□ Other _____
Barriers to Discharge: □ Discharge treatment setting not available □ Transportation
□ Legal Mandate □ Adequate Housing/Residence □ Lack of Community Support
□ Treatment Non-Compliance □ Other _____
Baseline Functioning: □Asymptomatic □ Manages Meds/Med Compliant
□ Functions Independently/ADLs Satisfactory □ Other _____
_____

Discharge Plan:
Expected Discharge Date: ___/___/___
Planned Discharge Program: □Outpatient □ Inpatient □ RTC
□ Rehab Day/Day Treatment □ Other

Planned Discharge Residence: □ Home (□Alone or □ w/others)
□RTC/Group Home □ Shelter
□Correctional Facility □ Foster Care □Respite
□Juvenile Detention □ Transfer to Medical □ Transfer to Alternate Psych. Facility
□ Other

Discharge Information: (*to be included upon discharge*)
Actual Discharge Date: ____/____/____
Primary Discharge Diagnosis: _____
Discharge GAF: _____ Discharge Condition: □ Improved □ No Change □ Worse

Treatment involved the following (check all that apply): □Adverse Incident
□Child Protection □ Family □ Legal System □ OP Provider
□Other Support Systems □ PCP □None □Other: _____

Note: Any adverse incidents must be reported immediately

Discharge plans in place? □Yes □No
Type of Discharge: □Planned or □ AMA PCP Notified □ Yes □ No

Actual Discharge Program: □Outpatient □ Inpatient

□RTC □ Day Treatment/Day Rehab
□Other _____
Actual Discharge Residence: □Home (□Alone or □ w/others)
□RTC/Group Home/ □ Shelter
□Correctional Facility □Foster Care □Respite
□Juvenile Detention □Transfer to Medical □Transfer to Alternate Psych. Facility
□Other: _____

Beneficiary/Family Member Name for Follow Up:

_____
Relationship: _____
Address _____
Phone #:_____ _____□Do not know
After Care Behavioral Health Provider: □Not arranged □ Do not know
After Care Provider Name: _____
After Care Provider Tel. #: _____
Scheduled Appointment Date: ____/____/____
Type of Appointment: □Mental Health □ Med Mgmt.

Prescribing Physician: □Not arranged □ Do not know
Prescribing Physician Name: _____
Prescribing Physician Tel #:_____
Prescriber: □PCP □ Psychiatrist □ Other Prescriber Type

_____ ____/____/____
Signature of Person Completing This Form Date