

**Behavioral Health Psychiatric Residential
Treatment Facility Referral Form**

Psychiatric residential treatment facility (PRTF) referral information

Date of referral: _____

Referral contact: _____ Referral facility/agency: _____

Phone number: _____ Fax number: _____

PRTF referrals made

Has the member been accepted at a PRTF? Yes No

If yes, please list actual facilities in the table below. If no, please list the potential facilities that the referring agency has identified as possible placements.

PRTF name	Accepted	Not accepted	Awaiting decision	Is this facility recognized by Louisiana DHH?
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Date of admission/potential admission to PRTF: _____



Demographic information (please print)			
Child's name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of birth:	Age:	Ethnicity:	Primary language:
Current placement:		Admission date:	
Social Security number:		Medicaid ID number:	
Address:			
City:		State:	Zip code:
Home phone number:			

Emergency contact (other than primary caregiver)	
Name:	
Relationship to child:	Languages:
Address:	
Home/cell phone:	Work phone:

Legal guardian (if other than listed above)	
Name:	
Relationship to child:	
Home/cell phone:	Work phone:



DCFS involvement (if applicable)	
DCFS supervisor:	Phone:
DCFS program supervisor:	Phone:
DCFS social worker area office:	Phone:
Reason and level of DCFS involvement:	
Client DCFS status: <input type="checkbox"/> Child is in custody <input type="checkbox"/> Investigation <input type="checkbox"/> Other:	

Juvenile court involvement (if any)	
Probation officer:	Phone:
Is the member in OJJ custody?: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Arrest history			
Criminal charge	When	Where	Disposition



Current family situation

Living situation (name/legal/relationship to member):

Family history, family psychiatric and substance abuse history, domestic violence, current family stressors that may be affecting patient:

Family's role in treatment:

Family's strengths:

Child's strengths:

Religious/cultural background:

Restrictions/special needs based on religious/cultural background or physical needs (if any):



Secondary insurance information (if any)

Name of secondary insurance carrier:	
Insurance number:	Plan code number:
Subscriber:	Date of birth:
Subscriber's employer:	Relationship to insured:
Insurance verified: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Psychiatric clinical information

What is the main clinical need or focal problem that leads you to request admission to a PRTF?

What are the contributing factors to the main clinical need/focal problem? Please consider factors from multiple life domains, including the individual, family, peer, school and community:

What are the goals for the PRTF stay and the recommended interventions corresponding to the contributing factors stated above?

Current diagnosis

DSM-5 diagnoses (include mental health, substance abuse and medical):

Current psychiatric medications and dosages

Name of drug/ symptoms behaviors	Dose	Schedule	Prescribing MD	Target

Were any medications discontinued due to adverse reactions? If so, which?



Has the child experienced any of the following? (please check one response)

Symptom/behavior/diagnosis	Current	Past	Unknown	N/A
Aggressive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention deficit disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dissociative features	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating patterns/concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations — auditory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations — visual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of cruelty to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Juvenile court involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runaway	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-injurious behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexualized behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Trauma history/abuse: Yes No Unknown

If yes, please explain when and by whom and if member has received any treatment:



Medical information

Primary care physician:	Phone:
-------------------------	--------

Allergies?

Check all that apply:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Head trauma
<input type="checkbox"/> Birth complications	<input type="checkbox"/> GI disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cardiac	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Thyroid disease

Medical issues — significant medical history, hospitalizations or surgeries:

Recent Test	Date	Abnormalities Y/N?	Explain
EKG		<input type="checkbox"/> Yes <input type="checkbox"/> No	
EEG		<input type="checkbox"/> Yes <input type="checkbox"/> No	
CT scan		<input type="checkbox"/> Yes <input type="checkbox"/> No	
MRI		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Identify any potential risk factors that may interact with medications:



Current medical medications:

Name of drug	Dose	Schedule	Prescribing MD	Test symptoms/ behaviors

Any medical conditions that might impact use of restraint?

Educational information

Child's current grade level:	Current school:
Special education classification? <input type="checkbox"/> Yes <input type="checkbox"/> No	Testing date:
Scores:	Current IEP date:

Academic, behavioral and social functioning in school. Note any suspensions:



Treatment history and plan

Has child ever received any of the following services?	Yes/No/Unknown	Where?
Psychiatric hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Substance abuse treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
CPST services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
CSoC waiver	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Outpatient treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Partial hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Residential treatment center	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Psych-sexual evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Psychological testing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Neuro-psych testing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other waiver services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

<p>What is the long-term disposition plan for this child?</p> <p><input type="checkbox"/> Reunification (if so, with whom?): _____</p> <p><input type="checkbox"/> Therapeutic foster care</p> <p><input type="checkbox"/> Residential treatment:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Group home: _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> Other: _____</p>	<p>What is the child's future vision for the long-term disposition plan?</p> <p><input type="checkbox"/> Reunification (if so, with whom?): _____</p> <p><input type="checkbox"/> Therapeutic foster care</p> <p><input type="checkbox"/> Residential treatment:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Group home: _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> Other: _____</p>
---	--



Current service providers				
Contact name	Agency	Phone	Services provided	Date of participation
Does the child require a single room? If yes, state reason:				
Previous experience with roommates:				

Substance use disorder ASAM dimensions				
Dimension rating (0 – 4)	Current ASAM dimensions are required			
Dimension 1: Acute intoxication and/or withdrawal potential Rating:	Substances used (pattern, route, last used):	Tox screen completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, results:	History of withdrawal symptoms:	Current withdrawal symptoms:
Dimension 2: Biomedical conditions and complications Rating:	Vital signs:	Is member under doctor care? <input type="checkbox"/> Yes <input type="checkbox"/> No Current medical conditions:	History of seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dimension 3: Emotional, behavioral or cognitive conditions and complications Rating:	MH diagnosis:	Cognitive limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Psych medications and dosages:	Current risk factors (SI, HI, psychotic symptoms, etc.):
Dimension 4: Readiness to change Rating:	Awareness/commitment to change:	Internal or external motivation:	Stage of change, if known:	Legal problems/probation officer:



Substance use disorder ASAM dimensions				
Dimension 5: Relapse, continued use or continued problem potential Rating:	Relapse prevention skills:	Current assessed relapse risk level: <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low	Longest period of sobriety:	
Dimension 6: Recovery/living environment Rating:	Living situation:	Sober support system:	Attendance at support group:	Issues that impede recovery:

Criteria section

Is the child/adolescent expected to: (check one)

Potential for improvement in symptoms/behavior with treatment

Treatment expected to maintain symptoms/behavior without further deterioration

Over the last week has the child/adolescent had any of the following behaviors? (check all that apply)

<input type="checkbox"/> Fire setting	<input type="checkbox"/> Angry outburst/aggression unmanageable
<input type="checkbox"/> Self-mutilation	<input type="checkbox"/> Positive psychotic symptoms unmanageable
<input type="checkbox"/> Runaway for more than 24 hours	<input type="checkbox"/> Hypomanic symptoms/increasing unmanageable
<input type="checkbox"/> Daredevil/impulsive behavior	<input type="checkbox"/> Arrest/confirmed/illegal activity
<input type="checkbox"/> Sexually inappropriate/aggressive/abusive	<input type="checkbox"/> Persistent violation of court order

Has the child/adolescent's behaviors been present at least six months? Yes No

Are the child/adolescent's behaviors expected to persist longer than one year without treatment? Yes No

Has child/adolescent had any of the following unsuccessful treatments within the past year? (check all that apply)

<input type="checkbox"/> Treatment foster care	<input type="checkbox"/> At least three psychiatric partial hospital admissions
<input type="checkbox"/> Residential treatment center/therapeutic group home	<input type="checkbox"/> At least four psychiatric admissions to inpatient/partial hospital/inpatient/outpatient in any combination
<input type="checkbox"/> At least three psychiatric inpatient admissions	

Are the child/adolescent's behaviors unable to be managed safely in a lesser level of care? Yes No

Is the child/adolescent's support system: (check any of the following):

<input type="checkbox"/> Unavailable	<input type="checkbox"/> Abusive
<input type="checkbox"/> Unable to ensure safety	<input type="checkbox"/> Intentional sabotage of treatment
<input type="checkbox"/> High-risk environment	<input type="checkbox"/> Unable to manage intensity of symptoms



Criteria section

Does the child/adolescent have any of the following functioning problems? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Unable/unwilling to follow instructions/
negotiate needs | <input type="checkbox"/> Unable/unwilling to perform ADL |
| <input type="checkbox"/> Socially withdrawn | <input type="checkbox"/> Behavioral control for more than 48 hours and
improvement is not expected within next two weeks |

Signature and title of referring person: _____ Date: _____

Supporting documentation required with packet:

- Court order for placement (if one exists).
- Most recent psychiatric evaluation recommending PRTF placement in order to complete the Certification of Need (CON).
- Most recent clinical update, including diagnosis and medications.
- Most recent IEP.
- Clinical justification: If the member has not had extensive OP services, please get clinical justification why the member needs to be placed in a PRTF as opposed to starting more intensive OP services.

Facilities may require additional documentation/information prior to approval/decision.