EA340 6/20

CONFIDENTIAL INFORMATION

SOUTH DAKOTA PRTF CONTINUED STAY REVIEW FORM
PSYCHIATRIC SERVICES UNDER 21

Recipient Name: Date of birth:

Referral Contact: Agency (if applicable):

Relationship: JCA ☐; CPS SW ☐; Parent ☐; BIA/Tribal ☐; School ☐; Other ☐
(If other, please explain)

Address:

Phone: Fax: E-mail:

PRTF Name: Phone:

Contact person: Admission date:

Estimated Length of Stay: Date sent to Certification Team:

Current Diagnosis

DSM V:

Psychiatric Medication:

Drug Name	Dosage	Date started

In the opinion of the interdisciplinary team please complete the following Criteria for Continued Stay (A, B and C):

A. ☐ Ambulatory care resources available in the community do not meet the treatment needs of the individual as evidenced by one of the following:
- ☐ Lower level of care is unsafe, placing individual at risk for imminent danger/harm;
- ☐ Clinical evidence that lower level of care will not meet recipient's needs;
- ☐ Medically necessary due to complicating concurrent disorders.

Outline reasons for selection:

B. ☐ Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician as evidenced by one of the following:

1. ☐ DSM V diagnosis and at least one of the following: and

Currently experiencing problems related to the DSM V disorder in one of the following categories;

- ☐ a. Self-Care – deficit due to Axis I impairment placing recipient at risk for self harm;
  - ☐ Deficit severe and long standing enough to prevent community setting placement;
  - ☐ Deficit placing the individual in a life threatening physiological imbalance without skilled intervention;
- ☐ b. Impaired Safety – The individual is exhibiting behaviors that present a serious threat to the welfare of himself or others as evidenced by one of the following:
  - ☐ Threat to self or others (verbalization or gestures);
  - ☐ Continued suicidal/homicidal ideation with plan of intent and/or continued violent/aggressive behaviors requiring seclusion or restraints;
  - ☐ Presenting symptoms severe enough to warrant residential treatment under the direction of a physician;
  - ☐ Verbal, physical and/or sexually aggressive behavior that poses a potential danger to self or others;
  - ☐ Conduct and/or anti-social behaviors of such severity that it places them or society at risk;
- ☐ c. Impaired Thought Process – inability to perceive/validate reality to extent that child cannot negotiate basic environment or participate in family/school life:
  - ☐ Disruption of safety to self, family, peer or community group;
  - ☐ Impaired reality testing sufficient to prohibit participation in community educational alternative;
  - ☐ Individual is not responsive to outpatient trial of medication or supportive care;
  - ☐ Individual requires inpatient diagnostic evaluation to determine treatment needs;
- ☐ d. Severely Dysfunctional Patterns – Family, environment, or behavioral processes placing child at risk:
  - ☐ Documentation of family environment, or behavioral processes placing child at risk;
  - ☐ Family situation non-responsive to outpatient or community resources or intervention;
  - ☐ Escalation of instability or disruption;
  - ☐ Severe behavior prohibits participation in lower level of care; **OR**

2. ☐ History of previous psychiatric diagnosis and posing an imminent danger to self and/or others: ; **OR**

3. ☐ In the absence of an identified DSM V diagnosis, individual must be exhibiting behaviors that present a serious threat to the welfare of himself or others as evidenced by one of the following:

- ☐ Symptoms severe enough to warrant residential treatment under the direction of a physician;
- ☐ Verbal, physical and/or sexually aggressive behavior that poses a potential danger to self or others; or
- ☐ Conduct and/or anti-social behaviors of such severity that it places them or society at risk:

C. ☐ The service can reasonably expect to improve the recipient's condition.
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Treatment Plan

☐ Treatment team has updated plan of treatment, identifying evidence that inpatient services are continuing to be required;

Discuss treatment plan goals: Date of plan changes, description of changes (update treatment since the last review);

Describe symptoms/progress from last certified day, please include specific symptoms/behaviors and dates);

Discuss service intensity since the last certified day (include MD visits, individual therapy, group therapy, family therapy, as well as precautions, seclusion etc.);

Family Involvement

Is the family involved in the child's treatment? Yes or No

If yes, please provide a summary of how the family is involved including whom and how often:

If no, please provide a summary of why they are not involved and efforts being made to involve them in treatment:

Note if the child has had any of the following:

Day Pass – an unsupervised outing with family to work on their relationships and practice new skills: ☐Yes; ☐No:
If yes how many has the child had each month since PRTF was approved or the last continued stay review:

Overnight Pass: ☐ Yes; ☐ No:
If yes how many has the child had each month since PRTF was approved or the last continued stay review:

Is the child employed outside of the facility: ☐ Yes; ☐ No:
If yes: How many days per week: Employer:
Number of hours per week:

Comments:

Referral or enrolled in Intensive Family Services program: ☐ Yes; ☐ No:
If yes: Which Community Mental Health Center:
If no: Is there a plan to make a referral and if no, why:

Discharge Plan

Tentative Discharge date:

Provide specifics on the tentative discharge plan including what needs to occur to accomplish discharge:

Have outpatient services been set up or sought out for when the child returns to the community? Yes or No

If yes, please outline the outpatient services that will be provided upon discharge:

If no, please provide a plan for setting up outpatient services upon discharge:

To be completed by referring PRTF:

I affirm that the information provided is a true and accurate description of the above named individual.

Signature: Date:

CERTIFICATION TEAM USE ONLY:

Continued stay in PRTF: ☐ APPROVED

Next review date: ☐ 180 days
☐ 90 days
☐ 30 days
☐ Other

Comments:

Continued stay in PRTF: ☐ DENIED

Denial Reason: