Initial Residential Treatment Center Review Form

Initial Review Section

Member Demographics & Authorization Details	
Member name/Medicaid number:	Admission date:
Submission date:	Attending physician name, credentials:
UR name/phone and fax numbers:	Facility name/state:

RTC prior authorization form for initial request attached (OP referral form)?   ☐ Yes   ☐ No
If no, provide reason:

Substance Use History
Current or historical substance use concerns:

Treatment History/Current OP Providers
Inpatient/outpatient treatment history:

Medications
Current medications (name, dosage, frequency):

Discharge Plan
Discharge planner name/phone number:

Discharge barriers:

Tentative discharge plan (please provide as much detail as possible):

Clinical Information

Primary diagnoses (BH, medical, comorbidities):

Primary reason for admission:

Ongoing symptoms, behaviors, functioning information, and risk factors to member requiring need for residential treatment (please note if any symptoms or behaviors have been persistent for six months or more):

Ongoing symptoms, behaviors, functioning information, and risk factors to member requiring need for residential treatment (please note if any symptoms or behaviors have been persistent for six months or more):

Personal and Social Context

Living arrangements prior to admission:

Education history (IEP, 504, homeschooled, low IQ, etc.):

Legal issues:

Planned Treatment Interventions Acknowledgment Checklist

Please acknowledge Yes or No for each of the following treatment interventions:

Clinical assessment completed daily
☐ Yes   ☐ No

Individual and/or family education
☐ Yes   ☐ No

Therapies by LMHP (including one individual therapy session weekly, two family therapy sessions monthly, total of five therapy sessions weekly)
☐ Yes   ☐ No

Psychiatric evaluation once a week by a Licensed Clinical Practitioner
☐ Yes   ☐ No

A current and updated treatment plan
☐ Yes   ☐ No

Participation in a school or vocational program
☐ Yes   ☐ No