AmeriHealth Caritas District of Columbia

Psychiatric Residential Treatment Facility Referral

Psychiatric Residential Treatment Facility (PRTF) Referral Information	
Date of referral:	
Referral contact:	Referring facility/agency:
Phone number:	Fax number:

PRTF Referrals Made

Has the member been accepted at an 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 the facility recognized as a PRTF by DC Medicaid? (Y/N)

Date of Admission/Potential admission to PRTF: _____

Demographic Information (Please print)		
Child's name:		☐ Male ☐ Female
Date of birth:	Age:	Ethnicity:
Current placement:		Admission Date:
SSN:	Primary language:	Medicaid ID number:
Address:		
City:	State:	ZIP Code:
Home phone number:		

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Emergency Contact (Other than Primary Caregiver): _____ Phone:_____

Parent – 1	Parent – 2
Name:	Name:
Relationship to child:	Relationship to child:
Ethnicity:	Ethnicity:
Languages:	Languages:
Address:	Address:
Home phone:	Home phone:
Work phone:	Work phone:

Legal Guardian (if other than listed above):		
Relationship to child:	Home phone:	Work phone:

DCYFS Involvement (if any)	
DCYFS supervisor:	Phone:
DCYFS program supervisor:	Phone:
DCYFS social worker/area office:	Phone:

Reason and level of DCYFS involvement:

Client DCYFS Status: ☐ OTC ☐ Committed ☐ Voluntary ☐ FWSN ☐ Investigation ☐ Protective

Juvenile Court Involvement (if any)	
Probation Officer:	Phone:

Arrest History:

Criminal charge	When	Where	Disposition

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Current Family Situation

Living situation (name/age/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:	DOB:
Subscriber's employer:	
Relationship to insured:	
Insurance verified: ☐ Yes ☐ 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:	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	

Current Psych Medications and Dosages:				
Name of Drug	Dose	Schedule	Prescribing MD	Target symptoms/behaviors

Past Psych Medication Trials:				
Name of Drug	Dose	Schedule	Prescribing MD	Target symptoms/behaviors

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

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

Symptom/Behavior/Diagnosis	Current	Past	Unknown	N/A
Aggressive behavior				
Anxiety / panic attacks				
Attention deficit disorder				
Depression				
Dissociative features				
Eating patterns / concerns				
Fire setting				
Hallucinations – Auditory				
Hallucinations – Visual				
History of cruelty to animals				
Homicidal threats				
Impulsive behavior				
Juvenile court involvement				
Oppositional behavior				
Runaway				
Self-injurious behavior				
Sexualized behavior				
School problems				
Sleep problems				
Suicidal attempts				
Suicidal ideation				

Trauma history/abuse: ☐ Yes ☐ No ☐ Unknown

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

Medical Information	
Primary care physician:	Phone:

Allergies?

Check all that apply:

☐ Birth complications ☐ Head trauma ☐ GI disease ☐ Diabetes ☐ HIV/AIDS

☐ Asthma ☐ Cardiac ☐ Thyroid disease ☐ Seizures

Medical issues – significant medical history, hospitalizations, surgeries, etc?

Recent Testing	Date	Any abnormalities? (Y/N)	Explain
EKG			
EEG			
CT Scan			
MRI			

Identify any potential risk factors that may interact with medications:

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Current Medical Medications:

Name of drug	Dose	Schedule	Prescribing MD	Target symptoms/behaviors

Any medical conditions that might impact use of restraint?

Educational Information	
Child's current grade level:	
Current school/town:	
Special education classification? ☐ Yes ☐ No	
IQ testing date:	IQ scores:
Current IEP date:	

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

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Treatment History and Plan		
Has child ever received any of the following services?	**Y/N/U**	**Where?**
Psychiatric hospitalization:		
Substance abuse treatment:		
CBI:		
MST:		
Outpatient treatment:		
Partial hospitalization:		
Residential treatment center:		
Psych-sexual evaluation:		
Psychological testing:		
Neuro-psych testing:		
Other:		
Other:		
Other:		
Other:		
Other:		

What is the long term disposition plan for this child? _____

☐ Reunification (if so, with whom) _____

☐ Therapeutic Foster Care _____

☐ Residential Treatment _____

☐ Group Home _____

What is the child's future vision for the long term disposition plan?

☐ Home ☐ Therapeutic Foster Care ☐ Residential Treatment ☐ Group Home

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Current Service Providers				
Contact Name	Agency	Phone	Service Provided	Dates of Participation

Does the child require a single room? If yes, state reason:

Previous experience with roommates:

Criteria Section

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

A. Potential for improvement in symptoms / behavior with treatment

B. Treatment expected to maintain symptoms / behavior without further deterioration

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

A. Fire setting

B. Self–mutilation

C. Runaway for more than 24 hours

D. Daredevil / Impulsive behavior

E. Sexually inappropriate / aggressive / abusive

F. Angry outbursts / Aggression unmanageable

G. Positive psychotic symptoms unmanageable

H. Hypomanic symptoms increasing unmanageable

I. Arrest / Confirmed illegal activity

J. Persistent violation of court orders

Has the child/adolescent's behaviors been present at least 6 months? ☐ Yes ☐ No

Are the child/adolescent's behaviors expected to persist longer than 1 year without treatment? ☐ Yes ☐ No

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

A. Treatment foster care

B. Residential treatment center / Therapeutic group home

C. At least 3 psychiatric inpatient admissions

D. At least 3 psychiatric partial hospital admissions

E. At least 4 psychiatric admissions to inpatient / partial hospital / intensive outpatient in any combination

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: (Circle any of the following):

A. Unavailable

B. Unable to ensure safety

C. High-risk environment

D. Abusive

E. Intentional sabotage of treatment

F. Unable to manage intensity of symptoms

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

A. Unable / Unwilling to follow instructions / negotiate needs

B. Socially withdrawn

C. Unable / unwilling to perform ADLs

D. Behavioral control for more than 48 hours and improvement is not expected within next 2 weeks

Signature/Title of Referring Person: _____ Date: _____

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Supporting documentation required with packet:

- Court order for placement (if one exists)
- Most recent psychiatric evaluation recommending PRTF placement
- 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 as to 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.