AmeriHealth Caritas
District of Columbia

Psychiatric Residential Treatment Facility Referral

Psychiatric residential treatment facility (PRTF) referral information	
Date of referral:	
Referral contact:	Referring facility or 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 facilities that the referring agency has identified for possible placement.

PRTF name	Accepted	Not accepted	Awaiting decision	Is the facility recognized as a PRTF by DC Medicaid? (Y/N)

Date of admission or potential admission to PRTF: _____

Demographic information		
Child's name:		☐ Male ☐ Female
Date of birth:	Age:	Ethnicity:
Current placement:		Admission date:
Social Security number:	Primary language:	Medicaid ID number:
Address:		
City:	State:	ZIP code:
Home phone number:		

Emergency contact (other than primary caregiver): _____ Phone:_____

Guardian 1	Guardian 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:

Child and Family Services Agency (CFSA) involvement (if any)	
CFSA supervisor:	Phone:
CFSA program supervisor:	Phone:
CFSA social worker or area office:	Phone:

Reason for and level of CFSA involvement:

Client CFSA status:					
☐ Order of Temporary Custody	☐ Committed	☐ Voluntary	☐ Family with service needs	☐ Investigation	☐ Protective

Juvenile court involvement (if any)	
Probation officer:	Phone:

Arrest history:

Criminal charge	When	Where	Disposition

Current family situation

Living situation (include the names and ages of other people in the household and their relationships to the member):

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

Family's role in treatment:

Family's strengths:

Child's strengths:

Religious and/or cultural background:

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

Secondary insurance information (if any)	
Name of secondary insurance carrier:	
Insurance number:	Plan or code number:
Subscriber:	Date of birth:
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 or 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 psychiatric medications and dosages				
Name of drug	Dose	Schedule	Prescribing M.D.	Target symptoms or behaviors

Past psychiatric medication trials				
Name of drug	Dose	Schedule	Prescribing M.D.	Target symptoms or behaviors

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

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

Symptom, behavior, or diagnosis	Current	Past	Unknown	N/A
Aggressive behavior				
Anxiety or panic attacks				
Attention-deficit/hyperactivity disorder				
Depression				
Disordered eating patterns or concerns				
Dissociative features				
Fire setting				
Hallucinations — auditory				
Hallucinations — visual				
History of cruelty to animals				
Homicidal threats				
Impulsive behavior				
Juvenile court involvement				
Oppositional behavior				
Running away				
Self-injurious behavior				
Sexualized behavior				
School problems				
Sleep problems				
Suicidal ideation				
Suicide attempts				

History of trauma or 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 provider:	Phone:

Allergies:

Check all that apply:

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

☐ Asthma ☐ Cardiac problems ☐ Thyroid disease ☐ Seizures

Medical issues (including significant medical history, hospitalizations, and surgeries)

Recent testing	Date	Any abnormalities? (Y/N)	Comment
Electrocardiogram			
Electroencephalogram			
Computed tomography scan			
Magnetic resonance imaging			

Identify any potential risk factors that may interact with medications:

Current medical medications:

Name of drug	Dose	Schedule	Prescribing M.D.	Target symptoms or behaviors

Any medical conditions that might impact use of restraint:

Educational information	
Child's current grade level:	
Current school or town:	
Special education classification? ☐ Yes ☐ No	
IQ testing date:	IQ scores:
Current individualized education plan (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?	**Y/N/U**	**Location**
Psychiatric hospitalization		
Substance use treatment		
Combined behavioral intervention		
Multisystemic therapy		
Outpatient treatment		
Partial hospitalization		
Residential treatment		
Psych-sexual evaluation		
Psychological testing		
Neuropsychological testing		
Other:		
Other:		
Other:		
Other:		
Other:		

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

☐ Reunification with the following person: _____

☐ Therapeutic foster care

☐ Residential treatment

☐ Group home

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

☐ Home ☐ Therapeutic foster care ☐ Residential treatment ☐ Group home

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

Expectation for treatment (check one):

- ☐ Treatment expected to improve symptoms or behaviors
- ☐ Treatment expected to maintain symptoms or behaviors without further deterioration

Over the last week, has the child or adolescent exhibited any of the following behaviors? (Check all that apply.)

- ☐ Fire setting
- ☐ Self-mutilation
- ☐ Running away for more than 24 hours
- ☐ Daredevil or impulsive behavior
- ☐ Sexually inappropriate, aggressive, or abusive behavior
- ☐ Angry outbursts or unmanageable aggression
- ☐ Positive, unmanageable psychotic symptoms
- ☐ Increasing, unmanageable hypomanic symptoms
- ☐ Arrest or confirmed illegal activity
- ☐ Persistent violation of court orders

Have the child or adolescent's behaviors been present at least six months? ☐ Yes ☐ No

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

Has child or adolescent had any of the following unsuccessful treatments within the past year? (Check all that apply.)

- ☐ Treatment foster care
- ☐ Treatment in a residential treatment center or therapeutic group home
- ☐ At least three psychiatric inpatient admissions
- ☐ At least three psychiatric partial hospital admissions
- ☐ At least four psychiatric admissions to inpatient, partial hospital, or intensive outpatient, in any combination

Are the child or adolescent's behaviors unmanageable safely in a lesser level of care? ☐ Yes ☐ No

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

- ☐ Unavailable
- ☐ Unable to ensure safety
- ☐ A high-risk environment
- ☐ Abusive
- ☐ Intentionally sabotaging treatment
- ☐ Unable to manage intensity of symptoms

Does the child or adolescent have any of the following functioning problems? (Check all that apply.)

- ☐ Inability or unwillingness to follow instructions or negotiate needs
- ☐ Social withdrawal
- ☐ Inability or unwillingness to perform activities of daily living
- ☐ Loss of behavioral control for more than 48 hours, with no improvement expected within two weeks

Signature and title of referring person: _____ Date: _____

Supporting documentation required with packet:

- Court order for placement (if applicable)
- 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 outpatient services, please provide clinical justification for placing the member in a PRTF instead of starting more intensive outpatient services

Please note: Facilities may require additional documentation or information prior to decision.

DHCF This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

5400ACDC-1522-31