RE-CERTIFICATION OF NEED
Adult Psychiatric Acute Hospital

Date of RON: _____ Time of RON: _____

Individual's Name:_____ Individual D.O.B.& Age: _____ - _____

Treating Facility: _____ Date of Admission_____

Title 19/21: Yes/No Emergency Admission: Yes No

1. DSM – IV Diagnostic Codes AXIS I _____; _____

AXIS II _____ **AXIS III** _____ **AXIS IV** _____ **AXIS V** ____

2. Reason for Hospitalization (Must meet specifications in at least one of a through m below - circle all that apply):

a. Individual requires hospitalization secondary to a serious suicide attempt and is assessed as posing a continued serious threat of significant self-harm.
b. Individual requires hospitalization secondary to a violent, dangerous, or destructive act and is assessed as posing a continued threat for continued like behaviors
c. Individual requires hospitalization secondary to a threat or evidence of intent to kill or injure another person and is assessed as posing a continued serious risk to others.
d. Individual requires hospitalization secondary to a loss of impulse control resulting in danger to self or others and is assessed as posing a continued serious risk to others.
e. Individual requires hospitalization secondary to command hallucinations directing harm to self or others, which have not sufficiently cleared to prevent likely harm to self or others.
f. Individual requires hospitalization secondary to experiencing persecutory delusions, which have not sufficiently cleared.
g. Individual requires hospitalized secondary to a life threatening rapid weight loss and has not sufficiently stabilized to safely transition to partial hospitalization or outpatient treatment.
h. Individual manifests major disability in social, interpersonal, occupational, or educational functioning leading to dangerous or life-threatening functioning, which can only be addressed in an acute inpatient setting.
i. Individual manifests a disorder of cognition or judgment with attendant psychological impairment, and family/community support cannot be relied on to provide essential care, without dangerous or life-threatening circumstances occurring.
j. Individual requires detoxification due to medical complications manifesting immediate physiologic jeopardy.
k. Individual has been approved for inpatient ECT treatment and the course of treatment will extend beyond the limits of the initial Certification of Need..
l. Individual presenting psychiatric signs/symptoms have substantially stabilized and can safely be transitioned to a less restrictive level of care; however that level of care is not available.
m. Other: (Specify) _____

3. Likely *therapeutic* discharge plan (Circle all that apply): Crisis Recovery Unit Alternative Care Bed Residential Mental Health Rx. Residential Chemical Dependency Rx. Residential Dual Diagnosis Rx. Supervised Day Program Therapeutic Day Program Medical Day Program Partial Hospital Program Outpatient Case Management Outpatient Medication Management Dialectical Behavioral Therapy Outpatient Counseling Personal Assistance ALTCS Services DDD Services

4. Estimated length of stay (Specify number): _____ Days (required)

5. Based upon physical, mental and social evaluations, I certify the above named individual requires inpatient psychiatric treatment and that all of the below accurately describes the situation for inpatient hospitalization according to 42 CFR Part 456 subpart C; under 21 42 CFR subpart D:

- Above circled items are fully documented in the individual's clinical record.
- Ambulatory care resources available in the community do not meet the treatment needs of the individual; and
- Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- Inpatient psychiatric services can reasonably be expected to improve the Individual's condition or prevent further regression so that the services will no longer be needed.

_____ _____ _____

Psychiatric Acute Hospital Physician's Name (Print) **Physician's Signature** **Date**

RON Valid for person 21 yo or older: Max is 60 days RON for person 20 yo or under : Max is 30 days

Call Magellan Care Management @ 1-800-564-5465 FAX CON to: 1-888-290-1285 Revised: 2/5/2014