CERTIFICATION OF NEED

Child and Adolescent Psychiatric Acute Hospital Admission

Date of CON: _____ / _____ / _____ Time of CON: _____

Individual's Name: _____ Individual D.O.B.: _____

Individual's Age: _____ Title 19/21: Yes No **Emergency admission**: Yes No

PNO/QSP Case Manager: _____ Psychiatric Acute Hospital: _____

1. **DSM IV TR Diagnostic Codes:** AXIS I _____ AXIS I _____ AXIS II _____

   AXIS III _____ AXIS IV _____ AXIS V _____

2. **Reason for Hospitalization (Must meet specifications in one of a through g - circle all that apply):**
   a. Individual manifests danger to self, as evidenced by at least one of the following:
      i. Individual expresses active suicidal ideation, with reasonable plan and available means, or
      ii. Individual expresses suicidal ideation with profound deficits of impulse control and reasonable clinical expectation of imminent serious self-injury, or
      iii. Individual's current inpatient psychiatric hospitalization was precipitated by a life threatening suicide attempt and antecedents have not been sufficiently identified/mitigated to warrant a less restrictive level of care.
   b. Individual manifests danger to others, as evidenced by at least one of the following:
      i. Individual expresses active homicidal ideation, with reasonable plan and available means, or
      ii. Individual expresses homicidal ideation with profound deficits of impulse control and reasonable clinical expectation of imminent serious other injury, or
      iii. Individual's current inpatient psychiatric hospitalization was precipitated by a life threatening homicide attempt and antecedents have not been sufficiently identified/mitigated to warrant a less restrictive level of care.
   c. Individual manifests profound psychiatric deficits, as evidenced by at least one of the following:
      i. Individual is experiencing internal stimuli to point of not being oriented to person, and severely impairs ability to perform activities of daily living, or
      ii. Individual requires daily seclusion/restraint.
   d. Individual requires specialty treatment, as evidenced by one of the following:
      i. Individual is being treated for life-threatening eating disorder and continues to require close monitoring to prevent self-injurious behaviors as a direct result of the eating disorder, or
      ii. Individual has been approved for inpatient ECT treatment.
   e. Individual requires detoxification due to medical complications manifesting immediate physiologic jeopardy.
   f. Individual is hospitalized for Court Ordered Evaluation.
   g. Other: (Specify) _____

3. **Likely discharge plan (Circle all that apply):** Partial Hospital Program Behavioral Health Inpatient Facility Behavioral Health Residential Facility Intensive Outpatient Services Outpatient Services Outpatient Medication Monitoring Outpatient Case Management Family Therapy Family Support Returning to Detention with Outpatient Services
   Other: _____

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 441 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

If above physician signature is from the Psychatric Acute Hospital treatment Team, then a physician independent of the Psychiatric Acute Hospital treatment team must certify this admission below on all Title 19/21 Individuals under the age of 21

_____ _____ _____ _____

Outpatient Physician's Name (Print) Independent Physician's Signature Date Agency