Adult Behavioral Health Residential Facility or HCTC Continued Stay Review

Form 3.14.4

Please Print Clearly

Provider Information		
Facility/Provider:	Staff Completing Form:	Credentials:
Address:		
City:	State:	Zip code:
Phone #:	Fax #:	Date of Admission:
Outpatient Provider:	PCP Name:	Phone:

Recipient Information			
Recipient's Name:	DOB:	Social Security Number:	
Address:			
City:	State:	Zip code:	Phone:

Current or Provisional DSM-IV Diagnosis		
	Code	**Description**
Axis I:		
Axis II:		
Axis III:		
Axis IV:		☐ Primary Support ☐ Social Environment ☐ Educational ☐ Occupational ☐ Housing ☐ Economic ☐ Access to Health Care ☐ Legal ☐ Other Psychosocial/Environmental
Axis V: (current):		Highest in past year:

Hospitalizations Since Admission (Attach additional sheets if needed)

Facility Name	Admission Date	Discharge Date	Reason for Admission

Current Medications - Psychiatric and Medical (Attach additional sheets if needed)

Medication	Dose	Schedule	Medication	Dose	Schedule

Effective Date: 02/05/2014

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List Any Barriers to Taking Medication as Prescribed (Such as availability, ability to purchase, etc.) (Attach additional sheets if needed)

List any UDS/BAL with dates, results and if positive interventions (Attach additional sheets if needed)

Continued Stay Review Staffing		
Date:		
Name	Title	Affiliation

Staffing Summary/Recommendations

Targeted Treatment Goals			
Measurable Objective	Treatment Intervention	Behaviorally Based Progress	Estimated Completion Date

Summary of Daily Activities (program participation, attendance, etc.)

Recipient Name:	SSN:

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Barriers to Greater Progress (if lack of progress, what changes have been made to the interventions to address the lack of progress. If new goals have been added, please define relevance to admission goals)
Current Risk
Progress (please describe the following)
Recipient's Current Mental Status:
Behavioral Needs:
Risk Factors:
Eating Habits:
Sleeping Habits:
Danger to Self:
Danger to Others:
Assaultive Behaviors:
Discharge Plan
Treatment Plan Attached ☐ Yes ☐ No
Comments

Recipient Name:	SSN: