

## PSYCHIATRIC ADMIT NOTIFICATION INFORMATION (For Individuals Under the Age of 21) (Please fill out completely)

## Return to Telligen by FAX (866) 539-0365

Facility Contact:	NPI #:		
Facility:			_
Participant's Name:		DOB:	M/F:
Participant's Address, County, Zip Code:			
Participant Phone Number:	Medicaid #:		
Admit Time/Date:	Urgent or Non-urge	nt Admit:	
Participant's Grade In School P	articipant's School:		
Parent(s) or Guardian(s) Name(s)			
Address (if different from above			
Phone (if different from above)			
Custodial Parent Name, Address & Phone	Number (if different from a	bove):	
Name of Person Consenting to Hospitalization	tion		
Relationship to Participant (address and ph	none number if different from	m above):	
Admitting Physician's Name:			
Admitting Physician's Address and Phone I	Number:		
Name, Address and Phone Number of Prin	nary Care Physician (if diffe	erent from above	ə):
Member of Healthy Connections:	Yes	No_	
Health Connection Referral: Yes	No		
Diagnosis and Codes:			



Participant Name:

## PSYCHIATRIC HOSPITAL REVIEW DOCUMENTATION REQUIREMENTS (For Individuals Under the Age of 21)

 Summary of present medical findings occurring within the last 24–72 hours, including symptoms, complaints, and complications indicating need for admission. Include the recent circumstances of this admission and <u>be specific regarding the time frames of the episode</u>. Also drug/alcohol history and testing.

Recent or current history of suspected physical or sexual abuse to the participant or by the participant
 If yes, please submit the following information:
 Reported by physician or facility to Children's Protective Services (CPS)? Yes No
 Name of individual who filed the report
 Date the report was filed

3) Treatment history including prior out of home placements, hospitalization, in-home services, individualized education plan (IEP) through the child's school. Indicate if this is the first psychiatric inpatient admission. <u>Also include current outpatient medications</u>.

4) Mental and physical capacity including domains in which the child or young adult is experiencing substantial impairment, i.e., home, school, community, or with peers.



Participant Name:

5) Specify the providers and/or individuals that are currently involved with this child or young adult and his/her family on an outpatient basis, if any.

6) Family resources, i.e., employment, cash assistance, SSI, and private insurance when available (referring physician or facility should have this information). Specify whether one or both parents live in the home.

7) Treatment plan: include information such as psychological testing, labs, medications, groups, role playing, school, precautions, seclusion, etc.

8) Discharge plan: indicate outpatient therapy anticipated. Include what, with whom, how long.

9) Prognosis:

10) Estimated length of stay: