BlueCare Tennessee

Psychiatric Residential Treatment Request Form (PRTF)

Please select the patient's health plan:

- ☐ BlueCare℠
- ☐ CoverKids
- ☐ TennCare*Select*

Request for inpatient residential level of care

Patient Member ID number: _____

Patient name: _____

Patient date of birth: _____ Patient contact number: _____

Initial: ☐ Yes ☐ No Concurrent: ☐ Yes ☐ No

If concurrent, please list the authorization number and fill out the remainder of this section.
Then, skip to the **Concurrent Review** and **Treatment and Discharge Planning** sections near the end of this form.

Authorization number: _____

Provider completing the form

Provider name: _____

Provider phone: _____

Provider fax: _____

Inpatient psychiatric facility

Requesting clinician: _____

Requesting provider _____

Clinician provider ID #: _____

Clinician NPI #: _____

Clinician address: _____

Treating provider

Provider name: _____

Clinician provider ID #: _____

Clinician NPI #: _____

Clinician address: _____

Requested facility

Facility name: _____

Facility provider ID #: _____

Facility NPI #: _____

Facility address: _____

Who has referred this patient for residential treatment services?

Name: _____ Phone: _____

Relationship to patient: _____

Psychiatric ICD-10 diagnosis codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Medical ICD-10 diagnosis codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Requested start date of service: _____

Units or number of days requesting: _____

Clinical Information

Date when the patient initiated their request for this service: _____

Describe in detail the patient's current condition (including their mental status and behavioral symptoms):

Why can't the patient be treated in a lower level of care at this time?

What attempts have been made to treat the patient with the maximum intensity of services available at less intensive levels of care (especially within the past six months)?

Fill out all that apply:

	Provider(s)	Frequency	Start date	End date	Comments
Medication management					
Individual therapy					
Comprehensive child and family treatment (CCFT)					
Family therapy					
Continuous treatment team (CTT)					
Partial hospitalization program (PHP)					
Intensive outpatient program (IOP)					
Psychiatric acute hospitalizations					
Applied behavioral analysis (ABA)					
Other community services					
Child protective services					
Arrests/legal charges					
Substance abuse					
School services					

Medications	Dose	Frequency	Dates	Outcome

Is the patient taking their medications as prescribed? Are there are any barriers to adherence?

Does the patient have cognitive or intellectual impairment? ☐ Yes ☐ No
Please note details, if applicable:

Describe the patient's current family structure (living situation, parental roles, supervision/structure, family strengths and areas needing improvement):

List the goals necessary and attainable for the patient/family within a residential treatment setting:

Are there any limitations for family participation in treatment (transportation, legal, etc.)?

☐ Yes ☐ No (If yes, please provide details.)

Patients Under 18

Fill out this section only if the patient is under the age of 18.

Who has custody of patient? _____

Is there any current CPS/DCS involvement? ☐ Yes ☐ No

How long has the patient been in DCS custody?

If the patient has DCS involvement, what is the Permanency Plan Goal?

What are the barriers to permanency goals?

What current symptoms or behaviors occur in the school setting?

Is the school involved in current treatment plan? ☐ Yes ☐ No

Is the patient involved with special education? ☐ Yes ☐ No

Eating Disorders

Fill out this section only if the patient has eating disorder issues.

Patient height: _____ Patient weight: _____

% Ideal body weight (IBW): _____ Current BMI: _____

Orthostatic blood pressure: _____

Standing: _____

Sitting: _____

Pulse rate: _____

EKG, electrolytes and other lab information:

Goal weight/BMI: _____

Last known episode of binging/purging/witholding: _____

Triggers for binging/purging/witholding: _____

Precipitant(s):

Sexual Offender Related Services

Fill out this section only if the patient needs sexual offender related services.

Presenting problem:

What is the patient's current involvement with the legal system and/or DCS? Please include specific current/past legal charges, details about DCS involvement and the exact time frames for each instance.

When was the last time these behaviors occurred? _____

In what setting do these behaviors occur?

Please list all individuals (including their corresponding ages) who live at home with the patient.

What is the current safety plan for at-risk individuals upon the patient's discharge?

Is the school setting involved in their current treatment plan? ☐ Yes ☐ No

Has a psychosexual assessment been completed prior to this request? ☐ Yes ☐ No
If yes, please attach the assessment. If no, please note a psychosocial assessment is required before Sex Offender Treatment (SOT) Residential Treatment Center (RTC) admission. Please provide additional detail explaining why the psychosexual assessment hasn't been completed.

Concurrent Review

Fill out this section for a concurrent review only. Then fill out the Treatment and Discharge Planning section.

What progress has been made since the last review in regards to symptoms, behaviors, diagnosis, etc.?

Are current suicidal/homicidal ideations or psychosis present? ☐ Yes ☐ No

What safety concerns necessitate continued 24-hour supervision? How are these addressed in treatment?

What therapeutic interventions were used to address safety issues? Explain how this level of care specifically addresses the patient's needs compared to other available levels of care.

Is the patient exhibiting any new behaviors or symptoms since admission? ☐ Yes ☐ No

Medication changes: ☐ Yes ☐ No

Have there been any restraints or seclusions within the last authorization period? ☐ Yes ☐ No

Please note dates and times as applicable below.

How is progress measured in treatment? If there has been no progress, how will you update the treatment plan?

Please list details (dates, times, attendees and other pertinent details) for family involvement (phone, education, family sessions and/or visitations):

If no family sessions have occurred, what attempts have been made to engage family and address barriers?

Treatment and Discharge Planning

What are the individualized attainable treatment plan goals and objectives for this level of care?

Are there any limitations for family participation in treatment (transportation, non-compliance, legal, etc.)?

☐ Yes ☐ No (If yes, please provide details.)

Anticipated discharge date: _____

Anticipated living location after discharge (at home with biological parents, DCS custody/placement, etc.):

Discharge plan:

What is the anticipated school transition plan after discharge?

Anticipated barriers to discharge:

Primary care provider name and efforts to coordinate care:

Signature of Ordering Clinician

The ordering clinician for this care must print and sign their name below. **Please note:** A signature is required to process this form, and only independently licensed providers can order care.

Printed name of ordering clinician, with credentials:

_____

Signature of ordering clinician, with credentials:

_____

Date of signature: _____

Fax pre-certification numbers:

Bluecare/TennCare*Select*: 1-800-292-5311
CoverKids: 1-800-851-2491

Customer service numbers:

BlueCare: 1-800-468-9736
TennCare*Select*: 1-800-276-1978
CoverKids: 1-800-924-7141

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