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YOUTH HOME

Outpatient Information for Residential Requests

Provider Name: _____ Contact number: _____

Beneficiary ID: _____ Last name: _____ First name: _____

Date form completed: _____

Psychiatric diagnosis (include all) during outpatient during OP treatment:

_____

_____

_____

Problems/Behaviors addressed in treatment plan: _____

_____

_____

_____

What progress/improvements observed (explain)? _____

_____

_____

Client/family strength (include natural supports): _____

_____

_____

_____

List all agencies contacts that are currently involved in the client's care (please include phone number): _____

_____

_____

Date client last attended individual therapy session: _____

Are sessions routinely missed? _____

Date client and family attended last family therapy session: _____

Is family active and involved? _____

Date client attended last medication management session: _____

Are meds being refused? _____

How often is client seen for medication management? _____

Was Crisis Interventions provided within the last 6 months to client or family? _____

Was there a positive outcome? (Describe) _____

_____

_____

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Outpatient Information for Residential Requests

Frequency of:

a.) Individual therapy from LMHP: _____ Total # of sessions within last 90 days_____

b.) Family therapy sessions from LMHP: _____ Total # of sessions within last 90 days _____

Other OP services received (frequency &type i.e. case management, rehab day, community supports): _____

_____

_____

Describe the current symptoms client is displaying in the school, community and at home that cannot be managed safely in an outpatient treatment setting: (specify if behavior only occurs in a specific setting):_____

_____

_____

List type(s) and date(s) of serious physically aggressive or destructive acts committed by the client in the last 30 days: _____

_____

_____

Legal charges? _____ (Describe, (reason/type)? _____

_____

_____

List the dates and length of stay of acute hospitalizations in last 12 months: _____

_____

_____

What will occur in the residential setting to support client return to family/community? _____

_____

_____

OP Clinic name: _____ City/Location: _____

Name/Signature of Therapist:_____ Date: _____

(**Additional documents may be submitted to support the request**)