# SOUTH DAKOTA PRTF CONTINUED STAY REVIEW FORM

## PSYCHIATRIC SERVICES UNDER 21

<table>
<thead>
<tr>
<th>Recipient Name:</th>
<th>Date of birth:</th>
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<tr>
<th>Referral Contact:</th>
<th>Agency (if applicable):</th>
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<tr>
<td>Relationship:</td>
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<tr>
<td>JCA [ ]</td>
<td>CPS SW [ ]</td>
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<tr>
<td>Parent [ ]</td>
<td>BIA/Tribal [ ]</td>
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<tr>
<td>School [ ]</td>
<td>Other [ ]</td>
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<tr>
<td>(If other, please explain)</td>
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<thead>
<tr>
<th>Address:</th>
<th>Phone:</th>
<th>Fax:</th>
<th>E-mail:</th>
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<tr>
<th>PRTF Name:</th>
<th>Phone:</th>
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<tr>
<th>Contact person:</th>
<th>Admission date:</th>
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<tr>
<th>Estimated Length of Stay:</th>
<th>Date sent to Certification Team:</th>
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## Current Diagnosis

<table>
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<th>DSM V:</th>
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## Psychiatric Medication:

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<tr>
<th>Drug Name</th>
<th>Dosage</th>
<th>Date started</th>
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In the opinion of the interdisciplinary team please complete the following Criteria for Continued Stay (A, B and C):

A. □ Ambulatory care resources available in the community do not meet the treatment needs of the individual as evidenced by one of the following:
   □ Lower level of care is unsafe, placing individual at risk for imminent danger/harm;
   □ Clinical evidence that lower level of care will not meet recipient’s needs;
   □ Medically necessary due to complicating concurrent disorders.

Outline reasons for selection:

B. □ Proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician as evidenced by one of the following:
   1. □ DSM V diagnosis and at least one of the following: and
      Currently experiencing problems related to the DSM V disorder in one of the following categories;
      □ a. Self-Care – deficit due to Axis I impairment placing recipient at risk for self harm;
         □ Deficit severe and long standing enough to prevent community setting placement;
         □ Deficit placing the individual in a life threatening physiological imbalance without skilled intervention;
      □ b. Impaired Safety – The individual is exhibiting behaviors that present a serious threat to the welfare of himself or others as evidenced by one of the following:
         □ Threat to self or others (verbalization or gestures);
         □ Continued suicidal/homicidal ideation with plan of intent and/or continued violent/aggressive behaviors requiring seclusion or restraints;
         □ Presenting symptoms severe enough to warrant residential treatment under the direction of a physician;
         □ Verbal, physical and/or sexually aggressive behavior that poses a potential danger to self or others;
         □ Conduct and/or anti-social behaviors of such severity that it places them or society at risk;
      □ c. Impaired Thought Process – inability to perceive/validate reality to extent that child cannot negotiate basic environment or participate in family/school life:
         □ Disruption of safety to self, family, peer or community group;
         □ Impaired reality testing sufficient to prohibit participation in community educational alternative;
         □ Individual is not responsive to outpatient trial of medication or supportive care;
         □ Individual requires inpatient diagnostic evaluation to determine treatment needs;
      □ d. Severely Dysfunctional Patterns – Family, environment, or behavioral processes placing child at risk:
         □ Documentation of family environment, or behavioral processes placing child at risk;
         □ Family situation non-responsive to outpatient or community resources or intervention;
         □ Escalation of instability or disruption;
         □ Severe behavior prohibits participation in lower level of care; OR

2. □ History of previous psychiatric diagnosis and posing an imminent danger to self and/or others; OR

3. □ In the absence of an identified DSM V diagnosis, individual must be exhibiting behaviors that present a serious threat to the welfare of himself or others as evidenced by one of the following:
   □ Symptoms severe enough to warrant residential treatment under the direction of a physician;
   □ Verbal, physical and/or sexually aggressive behavior that poses a potential danger to self or others; or
   □ Conduct and/or anti-social behaviors of such severity that it places them or society at risk:
C. The service can reasonably expect to improve the recipient’s condition.

### Treatment Plan

- Treatment team has updated plan of treatment, identifying evidence that inpatient services are continuing to be required;
- Discuss treatment plan goals: Date of plan changes, description of changes (update treatment since the last review);
- Describe symptoms/progress from last certified day, please include specific symptoms/behaviors and dates);
- Discuss service intensity since the last certified day (include MD visits, individual therapy, group therapy, family therapy, as well as precautions, seclusion etc.);

### Family Involvement

- Is the family involved in the child’s treatment? Yes or No
- If yes, please provide a summary of how the family is involved including whom and how often:
- If no, please provide a summary of why they are not involved and efforts being made to involve them in treatment:

### Note if the child has had any of the following:

- Day Pass – an unsupervised outing with family to work on their relationships and practice new skills: Yes; No:
  - If yes how many has the child had each month since PRTF was approved or the last continued stay review:
- Overnight Pass: Yes; No:
  - If yes how many has the child had each month since PRTF was approved or the last continued stay review:
- Is the child employed outside of the facility: Yes; No:
  - If yes: How many days per week: Employer:
  - Number of hours per week:
- Comments:

### Discharge Plan

- Tentative Discharge date:
- Provide specifics on the tentative discharge plan including what needs to occur to accomplish discharge:
- Have outpatient services been set up or sought out for when the child returns to the community? Yes or No
- If yes, please outline the outpatient services that will be provided upon discharge:
If no, please provide a plan for setting up outpatient services upon discharge:

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<tr>
<th>To be completed by referring PRTF:</th>
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<tr>
<td>I affirm that the information provided is a true and accurate description of the above named individual.</td>
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<th>Signature:</th>
<th>Date:</th>
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<th>CERTIFICATION TEAM USE ONLY:</th>
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<tbody>
<tr>
<td>Continued stay in PRTF: ☐ APPROVED Next review date: ☐ 180 days</td>
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<tr>
<td>☐ 90 days</td>
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<tr>
<td>☐ 30 days</td>
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<td>☐ Other</td>
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<th>Comments:</th>
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<tr>
<td>Continued stay in PRTF: ☐ DENIED</td>
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<td>Denial Reason:</td>
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South Dakota PRTF continued stay form 6/20 revision