AKBH Admission Review Questionnaire

Date of Review:

Name of Person providing Information:

PATIENT:
Name:
Medicaid ID # (if known):
Sex:
Date of Birth:
Age:
Ethnicity:
Plan Code: State of Alaska Behavioral Health
Client Code: State of Alaska Behavioral Health

CASE:
Notify (Date call received):
Treatment Setting: (IP/IP-OSS/RPTC):
Admit Date: (Actual date or proposed admit date):
Type: (Psychiatric or Residential):
Source: (Urgent or Non-Urgent):
Discharge (BLANK unless call for D/C):

DIAGNOSIS:
Axis I (Primary) Code:
Axis I (Secondary) Code:
Additional DX:
Additional DX:
Additional DX:

PROVIDER:
Facility Name:
Facility ID Number (if known):
Primary facility? Y or N:
Attending Physician/Psychiatrist Name:

TREATMENT PLAN:
Requested # of Days:
Begin Date:
To Date:
Notified Date: (Date of call/fax/submission to Qualis Health)
Source: Telephonic review or FAX review

1. Select Type of Review

- ☐ Acute: Emergency Admission
- ☐ Acute: Non-Emergency Admission
- ☐ RPTC: Expedited Admission
- ☐ RPTC: Non-Emergent Admission
- ☐ Retrospective (Use only if discharged)

2. Have the appropriate physician and/or persons certified the need for admission?

- ☐ Yes
- ☐ No

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3. Select Source of Referral (Select One):

- ☐ Acute Care-API
- ☐ Acute Care-Prov/Discovery
- ☐ Acute Care-North Star/Bragaw
- ☐ Acute Care- North Star/Main
- ☐ Acute Care-Other (Psychiatric General H)
- ☐ In-state RPTC-North Star/Debarr
- ☐ In-state RPTC-North Star/Palmer
- ☐ In-state RPTC-ACS
- ☐ In-state RPTC-Prov RPTC
- ☐ In-state RPTC-McCann
- ☐ BRS
- ☐ Private Clinic
- ☐ JJ
- ☐ RPTC OOS
- ☐ OCS
- ☐ Parent
- ☐ Foster Parent
- ☐ CBHC
- ☐ Police
- ☐ Hospital/Emergency Room
- ☐ Other: Enter information next question

4. Enter 'other' Referral Source _____

5. Select reason for Treatment Referral (Primary) (Select One):

- ☐ Suicidal Ideation/Attempt
- ☐ Homicidal Ideation/Attempt
- ☐ Aggression to Others
- ☐ Aggression to Self/Others
- ☐ Dual Dx
- ☐ Requires Locked Facility
- ☐ Running
- ☐ Sexual Acting Out
- ☐ Sexually Reactive Behaviors
- ☐ Self-Mutilating
- ☐ Psychotic Symptoms
- ☐ Eating Disorder

6. Select reason for Treatment Referral (Secondary)(Select One):

- ☐ Suicidal Ideation/Attempt
- ☐ Homicidal Ideation/Attempt
- ☐ Aggression to Self/Others
- ☐ Dual Dx
- ☐ Requires Locked Facility
- ☐ Running
- ☐ Sexual Acting Out
- ☐ Sexually Reactive Behaviors
- ☐ Self-Mutilating
- ☐ Psychotic Symptoms
- ☐ Substance Abuse
- ☐ Multiple Risk Factors
- ☐ Eating Disorder

7. Select Prognosis:

- ☐ Conditional
- ☐ Fair
- ☐ Good

8. Select primary reason for Secure Care (Select One):

- ☐ Dangerous to Self
- ☐ Dangerous to Others
- ☐ Dangerous to Property
- ☐ Runaway Behavior
- ☐ Impulsive/Out of Control Behavior
- ☐ Other: Enter information next question

9. Enter 'other' primary reason for Secure Care: _____

10. Ethnicity:

- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Hispanic
- ☐ Other
- ☐ Pacific Islander
- ☐ Unknown
- ☐ White

11. Has the recipient been adopted (by non-biological parents)?:

- ☐ Yes
- ☐ No

12. Name of guardian parent, adoptive parent, or social worker: _____

13. Select Custody Status:

- ☐ Non-custody
- ☐ JJ - Juvenile Justice
- ☐ OCS - Office of Children's Services

14. Select Region of Home Community (Select One):

- ☐ Anchorage
- ☐ Northern
- ☐ Southwest
- ☐ Southeast
- ☐ South-Central
- ☐ Mat-Su

15. Select Living Situation prior to this admission (Select One):

- ☐ Detention
- ☐ Family
- ☐ Foster Family
- ☐ Group Home
- ☐ Adopted Family
- ☐ Shelter
- ☐ RPTC
- ☐ Friends
- ☐ Relatives
- ☐ Homeless
- ☐ Other: Enter information next question

16. Enter 'other' Living Situation: _____

17. Name Last OOS RPTC: _____

18. Last OOS RPTC Admission Date (mm/dd/ccyy format): _____

19. Last OOS RPTC Discharge Date (mm/dd/ccyy format): _____

20. Name Last Acute Care (Psychiatric): _____

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21. Last Acute Care (Psychiatric) Admission Date (mm/dd/ccyy format): _____

22. Last Acute Care (Psychiatric) Discharge Date (mm/dd/ccyy format): _____

23. Name Last In-state RPTC: _____

24. Last In-state RPTC Admission Date (mm/dd/ccyy format): _____

25. Last In-state RPTC Discharge Date (mm/dd/ccyy format): _____

26. Name Last BRS (BRS=Behavioral Rehabilitation Services Level II, III, IV): _____

27. Last BRS Admission Date (mm/dd/ccyy format): _____

28. Last BRS Discharge Date (mm/dd/ccyy format): _____

29. Name Last Group Home: _____

30. Last Group Home Admission Date (mm/dd/ccyy format): _____

31. Last Group Home Discharge Date (mm/dd/ccyy format): _____

32. Select Level of Cognitive Functioning:

- ☐ IQ Above 70 (Average)
- ☐ IQ 55-70 (Mild)
- ☐ IQ 35-54 (Moderate)
- ☐ IQ 20-34 (Severe)
- ☐ IQ Below 20 (Profound)
- ☐ IQ Unknown

33. Does the recipient have an IEP?

- ☐ Yes
- ☐ No
- ☐ Unknown

34. Select applicable Trauma (Select all that apply):

- ☐ Natural Disaster
- ☐ Physical Abuse
- ☐ Domestic Violence (Witnessed)
- ☐ Sexual Abuse
- ☐ Emotional Abuse
- ☐ Death/Suicide
- ☐ Multiple Placements
- ☐ Neglect
- ☐ Multiple Losses
- ☐ Adopted
- ☐ None Identified
- ☐ Other: Enter information next question

35. Enter 'other' Trauma: _____

36. Enter date of last Mental Status Exam (mm/dd/ccyy format): _____

37. Select certification of person who performed or supervised the MSE:

- ☐ Physician
- ☐ Mental Health Professional
- ☐ Other

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38. Was the recipient receiving Outpatient Services (OP) prior to this admission?

- ☐ Yes
- ☐ No
- ☐ Unknown

39. If yes, enter name of the Primary OP provider and service provided: _____

40. Select Risk Factor/s (Select all that apply):

- ☐ Flight Risk
- ☐ Suicide Risk
- ☐ Homicide Risk
- ☐ Problems with ADLs
- ☐ Sexually Acting Out
- ☐ Aggression
- ☐ Non-Compliance with Treatment
- ☐ Legal Problems
- ☐ Family History MH
- ☐ Family History Substance Abuse
- ☐ Hx self-Mutilating
- ☐ Property Destruction
- ☐ School Suspensions
- ☐ None Identified
- ☐ Other High Risk Behaviors, Enter next

41. Enter "other" High Risk Behavior/s: _____

42. Is recipient a Sex Offender?:

- ☐ Not applicable
- ☐ Adjudicated
- ☐ Non-Adjudicated
- ☐ Unknown

43. Enter Axis II Diagnosis Code: _____

44. Enter Axis II Description: _____

45. Enter Axis III Description OR Code: _____

46. Select Axis IV Problems/Stressors (Select all that apply):

- ☐ Problem with Primary Support Group
- ☐ Problem related to Social Environment
- ☐ Educational
- ☐ Occupational
- ☐ Housing
- ☐ Economic
- ☐ Access to Health Care Services
- ☐ Legal System
- ☐ Other Psychosocial and Environmental

47. Enter Axis V GAF Score (0-100): _____

48. Select Co-Morbidity (Select all that apply):

- ☐ Thought D/O
- ☐ Mood D/O
- ☐ Substance Abuse
- ☐ Complicated Medical
- ☐ Eating D/O
- ☐ Developmental D/O
- ☐ FASD
- ☐ Suspected FASD
- ☐ Hx of Brain Injury

Medical Disability ☐
None Identified ☐
Other: Enter information next question ☐

49. Enter 'other' Co-Morbidity: _____

50. Initial Plan of Care (POC) (Select all that apply):

Activity and Recreational Therapies ☐
Baseline Assessment of Functioning ☐
Collaboration with Care Coordinator ☐
Contacts with JPO, OCS, JJ, if required ☐
Crisis/Safety Plan Intervention ☐
Educational Needs Assessment/Plan ☐
Evaluation of Strengths ☐
Family Psychotherapy ☐
Further Diagnostic Evaluation ☐
Group Psychotherapy ☐
Group Skill Development Services ☐
Identified Strengths of Recipient ☐
Individual Psychotherapy ☐
Individual Skill Development Services ☐
Measurable Objectives for each Problem ☐
Neuropsych Testing ☐
Nutritional/Diet Screening and Planning ☐
Pharmacologic Management ☐
Physical Examination ☐
Psychosocial History ☐
Substance Abuse Assessment ☐
Tx Goals/Problems Identified ☐
Other: Explain in #50 ☐

51. Enter 'other' Planned Treatment: _____

52. Has the POC been formulated in consultation with the recipient (for adults) or recipient and the guardian (for minors)?

Yes ☐
No ☐

53. The diagnostic evaluation includes examination of medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for acute care.

Yes ☐
No ☐

54. Enter Anticipated Discharge Date (Enter in mm/dd/ccyy format): _____

55. Document the answers to the following questions **in Additional Comments at the bottom of the previous page**. Use the Copy and Paste function. Highlight, right click, select Submit Questionnaire, paste (right click) into Clinical Findings box.

56. Anticipated Discharge Plan (Must clearly specify post-discharge service needs including any prospective post-discharge service providers and any other provision necessary for transition to a lesser restrictive environment and adult services):

_____

57. Describe acute disturbances related to the behavioral disorder:

_____

58. Brief description of Psychosocial History (include explanation of trauma events):

_____

59. Initial Plan of Care (Goals and objectives that are measurable and individualized):

_____

60. Medication History-List medication history, including a statement on current medications. Note any medication concerns, or compliance issues for each medication, if that history is known:

_____

61. List Safety Precautions in place: _____