

AKBH Continued Stay Questionnaire

1. Select type of Continued Stay Review: Answer ONLY the questions that are PERTINENT to the TYPE OF REVIEW you are requesting. For TRIAL DISCHARGE HOME PASS, please answer ONLY if review period is before 11/01/2010):
- Concurrent questions 1-14
Master POC 1-3 & 16-27 ONE TIME ONLY
Trial Discharge Home Pass 1-3 & 29-34
TTD – Same as Concurrent
2. Select current Custody Status:
- Non-custody
JJ - Juvenile Justice
OCS - Office of Children's Services
3. Enter Anticipated Discharge Date (Date of discharge must be based on individualized goal achievement per psychiatric treatment progress/needs, rather than program completion. mm/dd/ccyy format):
- _____
4. Enter Axis II Diagnosis Code: _____
5. Enter Axis II Description: _____
6. Document answers #7-14 for CONCURRENT Review 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.
7. Describe acute disturbances, self care deficits or imminent risk to self, others, impaired safety or severely impaired role functioning (e.g. thought disorders or other acute disturbances pertaining to the primary and (if any) secondary diagnoses):
- _____
8. Updated Plan of Care Treatment Goals (Updated diagnosis and treatment plan. Specify the measurable goals and progress on treatment plan and in weekly Individual, Family and Group Psychotherapies):):
- _____
9. List Safety Precautions in place: _____
10. ANY Medication changes (Date ordered and D/C, Dosage/Route, Frequency, Compliance, Drug level, if applicable and effectiveness):
- _____
11. Legal charges during this review period: _____
12. Medical services provided during this review period: _____
13. Updated DC Plan (Placement, Tx needs, anticipated providers, education svcs, community supports, individualized svcs, respite svcs, medical needs. Add contact information. List concerns and efforts towards timely discharge):
- _____
14. List Diagnostic testing planned with results and recommendations since last review:
- _____

AKBH Continued Stay Questionnaire

15. MASTER PLAN OF CARE (MPOC) Questions #16-27 are to be answered ONE TIME ONLY with MPOC REVIEW.

16. Select the elements included in the written MPOC for this recipient (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 Recipient's 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 Question #17 and/or #18

17. Explain 'other' element (as above): _____

18. Explain 'other' element (as above): _____

19. Enter Axis II code: _____

20. Enter Axis III Description OR Code: _____

21. Has the MPOC been formulated in consultation with the recipient and/or the recipient's family or guardian?

Yes
No: Explain in next question

22. If the previous answer is 'No', please explain: _____

23. MPOC ONLY - Document the answers to #24-27 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 the Clinical Findings box.

24. ALL Medications (Date ordered and D/C, Dosage/Route, Frequency, Compliance, Drug level, if applicable, and effectiveness):

25. List Safety Precautions in place: _____

AKBH Continued Stay Questionnaire

26. List the identified problems statement and their measurable goals according to their related diagnosis. Note specific measurable goals related to Individual, Family, and Group Therapies:

27. Discharge Plan (Based on treatment goals and objectives, specifies approx DC date based on achievement of those stated objectives and post D/C svcs. Must be continually updated to reflect changes and progress in treatment planning):

28. TRIAL DISCHARGE HOME PASS ONLY - Questions #29-34 (Please answer ONLY if review period is before Nov. 1, 2010):

29. Start date of Pass (mm/dd/ccyy format): _____

30. End date of Pass (mm/dd/ccyy format): _____

31. Enter name of escort: _____

32. Enter name of therapist requesting home pass: _____

33. Document the answer to the following question 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 the Clinical Findings box.

34. Plan of Care for Trial Discharge Home Pass: Include-Goals & Objectives, Crisis Plan, OP Tx with names, dates and agreed upon goal. Describe any plan to make contact with the school:
