



Adult Level II, III and HCTC Continued Stay Review

Form 3.14.4

Please Print Clearly

Provider Information

Facility/Provider:	Staff Completing Form:	Credentials:
Address:		
City:	State:	Zip code:
Phone #:	Fax #:	Date of Admission:
Outpatient Provider:	PCP Name:	Phone:

Recipient Information

Recipient's Name:	DOB:	Social Security Number:
Address:		
City:	State:	Zip code:
		Phone:

Current or Provisional DSM-IV Diagnosis

	Code	Description
Axis I:		
Axis II:		
Axis III:		
Axis IV:		<input type="checkbox"/> Primary Support <input type="checkbox"/> Social Environment <input type="checkbox"/> Educational <input type="checkbox"/> Occupational <input type="checkbox"/> Housing <input type="checkbox"/> Economic <input type="checkbox"/> Access to Health Care <input type="checkbox"/> Legal <input type="checkbox"/> Other Psychosocial/Environmental
Axis V: (current):		Highest in past year:

Hospitalizations Since Admission (Attach additional sheets if needed)

Facility Name	Admission Date	Discharge Date	Reason for Admission

Current Medications - Psychiatric and Medical (Attach additional sheets if needed)

Medication	Dose	Schedule	Medication	Dose	Schedule



Adult Level II, III and HCTC Continued Stay Review

Form 3.14.4

List Any Barriers to Taking Medication as Prescribed (Such as availability, ability to purchase, etc.) (Attach additional sheets if needed)

--

List any UDS/BAL with dates, results and if positive interventions (Attach additional sheets if needed)

--

Continued Stay Review Staffing

Date:

Name	Title	Affiliation

Staffing Summary/Recommendations

--

Targeted Treatment Goals

Measurable Objective	Treatment Intervention	Behaviorally Based Progress	Estimated Completion Date

Summary of Daily Activities (program participation, attendance, etc.)

--

Recipient Name:	SSN:
-----------------	------



Adult Level II, III and HCTC Continued Stay Review Form 3.14.4

Barriers to Greater Progress (if lack of progress, what changes have been made to the interventions to address the lack of progress. If new goals have been added, please define relevance to admission goals)

Current Risk

Progress (please describe the following)

Recipient's Current Mental Status:

Behavioral Needs:

Risk Factors:

Eating Habits:

Sleeping Habits:

Danger to Self:

Danger to Others:

Assaultive Behaviors:

Discharge Plan

Treatment Plan Attached Yes No

Comments

Recipient Name:

SSN: