Connecticut BHP
Supporting Health and Recovery

PRTF Referral Form

SERVING

The Children's Center of Hamden	Albert J. Solnit South Campus PRTF	Albert J. Solnit North Campus PRTF	The Village for Families & Children	Boys and Girls Village
1400 Whitney Avenue Hamden, CT 06517 T: 203-248-2116 F: 203-248-2572 *Males ages 7-16* *Females ages 7-16*	915 River Road Middletown, CT 06457 T: 860-704-4082 F: 860-772-1749 *Females ages 13-17*	36 Gardner Street East Windsor, CT 06088 T: 860-292-4000 F: 860-292-4066 *Males ages 13-17*	1680 Albany Avenue Hartford CT 06105 T: 860-297-0585 F: 860-523-0346 *Males ages 6-12* *Females ages 6-12*	528 Wheelers Farms Road Milford, CT 06461 T: 475-261-1711 F: 203-783-9572 *Males ages 11-17*

ATTENTION:
Before continuing with this referral, please read the information below and refer to the CTBHP level of care guidelines to determine if a referral to PRTF is clinically appropriate. Guidelines can be found at:
http://www.ctbhp.com/providers/pdfs/Child_BHP_Level_of_Care_Guidelines.pdf

Program Description:

Psychiatric residential treatment facility (PRTF) are community based inpatient facilities that provide psychiatric and other therapeutic and clinically informed services to individuals under age 21 according to Federal Medicaid Law.

PRTFs are appropriate for members who require a structured 24-hour inpatient residential setting that provides all required services (including schooling) on site while simultaneously preparing the child/adolescent and family for ongoing treatment in the community. The level of care is less intensive than acute inpatient hospitalization and more restrictive than residential treatment or home and community-based treatment, including partial hospitalization and home-based services.

Authorization Process and Time Frame for Service:

This level of care requires prior authorization. Each case will be reviewed on an individual basis for medical necessity. Upon submission, referral and all associated clinical documentation will be reviewed by Carelon Behavioral Health on behalf of CT BHP. If referral is deemed clinically appropriate and medically necessary, it will be approved and sent to all PRTF facilities for which the youth is eligible. Approval will be valid for 60 days counting from the date the referral was reviewed by Carelon Behavioral Health. If admission does not occur within the that period, the approval will expire and a new PRTF referral will be required. Referring providers have the option to continue to provide updated clinical information every 30 days if they wish the referral to remain open. Upon initial and all subsequent approvals, a letter will be generated informing of the decision and approval time frames. For any questions, please call Carelon CT BHP at 1-877-552-8247.

The expected length of stay is between 15 and 30 days for children/adolescents diverted from acute inpatient hospital care, and 30 and 120 days for children/adolescents stepped down from acute inpatient hospital care, depending on clinical and dispositional needs.

Required clinical information:

When completing this referral, please make sure to provide:

Accurate and detailed information about history of the following services: in-home services, including, but not limited to IICAPS, MDFT, partial hospitalization (PHP), intensive outpatient services (IOP), previous admissions to inpatient psychiatric units, previous admissions to Solnit inpatient unit, previous admissions to PRTF, and outpatient services including date of last evaluation by a psychiatrist or APRN.

Clinical reasons that make IICAPS, MDFT and other higher intensity lower levels of care, such as IOP and PHP inappropriate levels of service.

For patients in the inpatient, setting, please indicate the dates and number of episodes of physical restraints, seclusion, intramuscular medications to prevent injury, harm to self or others, need for increased observation (1:1, and or checks every 5 minutes).

Copy of the intake/admission note, and the notes for the three most recent visits. Include history of medication changes throughout course of treatment*Facilities may require additional documentations/information prior to approval/decision

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PLEASE FAX TO CT BHP: 855-584-2172 – ATTN: CLINICAL DEPARTMENT
OR
EMAIL TO: CTBHPReferralSubmit@carelon.com
For youth with commercial insurance, please fax this referral directly to the provider.

Date of Referral ________________________

Referring Person ___________________________ Referring Facility ______________________

Phone # __________________________________ Fax # ______________________________

Address: ____

Email: ____

Date of Admission to Hospital: ___________________________

Demographic Information (*PLEASE PRINT)*

Child's name: ____ Gender: _____________

Date of birth: ___________________ Age: _____ Race: ______________ Ethnicity: ________________

Current location of patient: ______________________ Admission Date: ______________________

SSN: ________________________________ Primary Language: ______________________

Address: ____

City/State/Zip code: ____

Home phone: _____________________________________

Emergency Contact (Other than Primary Caregiver): _____________________________________

Phone: ________________________________ Email: ____________________________________

	Parent 1	Parent 2
Name		
Relationship to Child		
Ethnicity		
Languages		
Address		
Home/Cell Phone		
Work Phone		
Email		

Legal Guardian (if other than listed above) Name: ____
Relationship to child: ________________ Phone: _____________________ Email: __________________

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DCF Involvement (if any):

DCF Status: ☐ OTC ☐ Committed ☐ Investigation ☐ Protective Services ☐ In-Home

Person ID: ______________________ Area Office: ________________________

DCF Supervisor:	Phone:	Email:
DCF RRG:	Phone:	Email:
DCF Program Supervisor:	Phone:	Email:
DCF Social Worker:	Phone:	Email:

Voluntary Care Management (VCM) Involvement (if any):

Voluntary Care Manager: ________________________________ Phone: __________________

Email: _________________________________

Juvenile Court involvement (if any):

Probation officer:_______________________________ Phone: ______________________

Email: ____

Arrest History and Offence (*when and why)*

Insurance information:

Medicaid **Yes** **No** Medicaid ID:____

Medicaid Package (Husky A, B, Limited):

Commercail Insurance Carrier

Phone number:	
ID:	Group:
Subscriber:	DOB:
Subscriber Employer:	Relationship to Insured:

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Current Diagnosis:

Behavioral Diagnoses (*Primary is required)*

Code	**Diagnosis**
Code	Diagnosis
Code	Diagnosis
Code	Diagnosis

Medical Diagnoses (if no diagnosis, indicate "None" or "Unknown")

Code	Diagnosis
Code	Diagnosis

Current Medications and Dosages*: Note if medication is psychotropic or medical

Name of Drug	Dose	Schedule	Prescribing MD	Target Symptoms/Behaviors

Past Medication Trials: Note if medication is psychotropic or medical

Name of Drug	Dose	Schedule	Prescribing MD	Target Symptoms/Behaviors

*For referrals initiated in the inpatient setting, include a copy of the medication sheet showing total daily dose for each medication during this admission and for referrals initiated in the outpatient setting, include a copy of the medication history showing all the changes in medications and doses over the course of treatment.

Is the prescriber making active medication changes? If so, what?

Treating psychiatrist, psychologist or APRN: ____________________ **Phone:** ______________________

Date of last evaluation:

Pediatrician or family physician: ______________________________ **Phone:** ______________________

Allergies:

Medical Issues – Significant medical history, hospitalizations?

Any medical conditions that might impact during use of restraint:

Check all that apply:

Birth complications	Head Trauma	GI Disease	Seizures	Asthma
Cardiac	Thyroid disease	Diabetes	HIV / AIDS	

Recent Testing/EKG/EEG/CT Scan/MRI? If yes, when? Any abnormalities?

Identify any potential risk factors that may interact with medications:

*For referrals initiated in the inpatient setting, please indicate the dates, and time of each episode of restraint, seclusion, intramuscular medication for agitation, aggressive, or self-injurious behavior, increased observation (1:1).

*Please include the number of doses, if any, of extra medication, "as needed", on the three days preceding this referral.

Safety Interventions Needed – 3 most recent

Intervention (Restraint, seclusion, PRN)	
Date and time	
If PRN, medication type (IM, PO), name, dose	
Reason safety intervention needed	
Outcome of safety intervention	

Intervention (Restraint, seclusion, PRN)	
Date and time	
If PRN, medication type (IM, PO), name, dose	
Reason safety intervention needed	
Outcome of safety intervention	

Intervention (Restraint, seclusion, PRN)	
Date and time	
If PRN, medication type (IM, PO), name, dose	
Reason safety intervention needed	
Outcome of safety intervention	

Family Dynamic:

Living Situation (where is the patient residing, for how long, who else lives in the household):

Family History, family psychiatric and substance abuse history, domestic violence, current family stressors that may be affecting patient:

Family's role in treatment:

Family's Strengths:

Child's Strengths:

Religious/Cultural Background:

Restrictions/Special Needs based on religious/cultural background (if any):

School Performance*:

Child's Current Grade Level: ____________ Current School/Town: __________________________________

Special Education Classification: Yes No Last PPT: __________________________________

IQ Scores: ______________________________ IQ Testing Date: __________________________________

Please attach results of any school based testing.

Academic, Behavioral & Social Functioning in School. Note any suspensions, truancy, school refusals:

Treatment History:

Current Service Providers (Name, Agency, Phone, Service Provided & Dates of Participation):

Has child ever received any of the following services? (If so, please identify where/when)

Psychiatric hospitalization:________________________________ ☐ **yes** ☐ **no** ☐ **unknown**

Below, please provide agency name and date:

Substance Use Treatment	Yes	No	unknown
In-Home Services (specify program)	Yes	No	unknown
Outpatient Treatment	Yes	No	unknown
Partial Hospital Program / IOP	Yes	No	unknown
Residential Treatment Center	Yes	No	unknown
Psycho-Sexual Evaluation	Yes	No	unknown
Psychological Testing	Yes	No	unknown
Other	Yes	No	unknown

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Child's Presentation:

Has the child ever experienced the following? Please check one and comment for all current or past selections

	Current	Past	Unknown	N/A	Comments
Aggressive behavior					
Anxiety/panic attacks					
ADHD					
Depression					
Dissociative Features					
Eating Patterns/Concerns					
Fire Setting					
Hallucinations					
Cruelty to Animals					
Homicidal Threats					
Impulsive Behavior					
Oppositional Behavior					
Run Away					
Disrupted Attachments from caregiver					
Self-Injurious Behavior					
Sexualized Behavior					
School Problems					
Sleep Problems					
Suicide Attempts					
Suicidal Ideation					

What is the main clinical need that leads you to request admission to a PRTF?

What are the contributing factors to the main clinical need? Please consider factors from multiple domains including the individual, family, peer, school, and community:

Child's Trauma History:

Adverse Childhood experiences:

Parent History of behavioral health, substance use, cognitive limitations:

Safety Concerns (Suicidal ideation/attempt, Homicidal ideation/attempt, runaway, aggressive behavior, self-injury, etc.)

What are the goals for the PRTF stay and the recommended interventions corresponding to the contributing factors stated above?

What is the concurrent plan to PRTF?

Intended plan following PRTF treatment:

What is the long-term disposition plan for this child? Reunification (if so, with whom)

Does the child require a single room? If yes, state reason:

Previous experience with roommates:

Signature/Title of Referring Person Date