

## Family Focused/Solution Based Services 24 Week review/ISPT Meeting

IDENTIFYING INFORMATION		
Date:	Member Name:	MA #:
		SSN:
Date of Birth/Age:	Provider:	

Requested Start Date for Authorization:		Admit Date:	
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CURRENT DIAGNOSIS	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V: (GAF Current)	
Any revision to diagnosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Member's Risk to Self:</b>  <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)	<b>Member's Risk to Others:</b>  <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)
Has a crisis/safety plan been updated in collaboration with the family?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Number of crisis calls in the past 12 weeks:	
<i>Please describe:</i>	

## Current Impairments

Key:

0 (None)    1 (Mild or Mildly Incapacitating)    2 Moderate or Moderately Incapacitating    3 (Severe or Severely Incapacitating)    NA (Not Assessed)

<b>Mood Disturbances (Depression or Mania)</b>	<b>Weight Loss Associated with an Eating Disorder</b>	<b>Anxiety</b>
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

<b>Medical/Physical Conditions</b>	<b>Psychosis/Hallucinations/Delusions</b>	<b>Substance Abuse/Dependence</b>
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

<b>Thinking/Cognition/Memory/Concentration Problems</b>	<b>Job/School Performance Problems</b>	<b>Impulsive/Reckless/Aggressive Behavior</b>
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

<b>Social Functioning Relationships/Marital/Family Problems</b>	<b>Activities of Daily Living Problems</b>	<b>Legal</b>
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

<b>LIST ONGOING GOALS / OBJECTIVES IN MEASUREABLE TERMS:</b>

<b>IDENTIFIED GOALS AND / OR OBJECTIVES ALREADY ACHIEVED:</b>

<b>CURRENT RATES OF BEHAVIOR (list each separately):</b>

<b>PROBLEMATIC BEHAVIOR CONTINUING TO PUT THE CHILD / ADOLESCENT AT RISK FOR OUT-OF-HOME TREATMENT:</b>

<b>NEW RESOURCES OR COMMUNITY SUPPORTS IDENTIFIED DURING THE FIRST 28 WEEKS (please list):</b>

<b>EDUCATIONAL STATUS</b>	
Last contact with school:	
Any changes reported at school? <i>(Please list)</i>	

<b>CURRENT FAMILY CONCERNS / EXPECTATIONS FOR ONGOING TREATMENT:</b>

Has child been Inpatient at any time in this past auth period?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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<b>MEDICATIONS</b>		
<b>NAME</b>	<b>DOSE</b>	<b>FREQUENCY</b>
Prescribing psychiatrist:		
Any revision to medication in past 12 weeks? <i>(Please list)</i>		
Date of last medication monitoring appointment and with whom?	Date:	With:
Has the member / family been compliant with medications as prescribed:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
If no, why?		

REASON FOR CONTINUED STAY:

IDENTIFIED TREATMENT BARRIERS CONTINUING TO PREVENT PROGRESS IN TREATMENT:

BASELINE BEHAVIOR AT BEGINNING OF TREATMENT (list each identified behavior separately):

EXPECTED DISCHARGE DATE:		WITHIN 32 WEEKS?		DATE OF RE-EVALUATION IF NOT BEING DISCHARGED:	
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PLANNED DISCHARGE Level of Care:		PLANNED DISCHARGE RESIDENCE:	
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