

# DDM North Dakota Under 21 Psychiatric Residential Treatment Facility (PRTF) Review Form

Enter Online at [www.PASRR.com](http://www.PASRR.com).

<b>Facility Name:</b>		Phone:					
Contact Person:		Fax#:		Date Sent to DDM:			
Attending Physician:				Date of Admission:			
License # :		Type: (check one) <input type="checkbox"/> PRTF Elective <input type="checkbox"/> PRTF CSR <input type="checkbox"/> Retrospective					
(last)      (first)      (middle)		Patient Name:			Date of Birth:		
Social Security # :		Medicaid Applicant <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid Application Date:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					
Admit Date:			Tentative or Actual Discharge Date:				
<b>Tentative Discharge Plans</b>			<b>Progress Toward Discharge</b>		<b>Approx Date</b>		
<b>Responsible Party Name:</b> _____ Phone: _____							
If CSR, has the responsible party changed since last review? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Parents <input type="checkbox"/> Court <input type="checkbox"/> Gov. Agency <input type="checkbox"/> Other (specify): _____							
Address:		City:		State:	Zip:	County:	
<b>Living Arrangements:</b> <input type="checkbox"/> Alone <input type="checkbox"/> Court <input type="checkbox"/> Parents <input type="checkbox"/> Relatives <input type="checkbox"/> Non-Relatives <input type="checkbox"/> Group Home							
<input type="checkbox"/> Spouse <input type="checkbox"/> Foster Home <input type="checkbox"/> PRTF <input type="checkbox"/> Other (specify): _____							
<b>Prior <u>Inpatient</u> Treatment:</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (Complete history include <u>Substance</u> and Behavioral Health)							
<input type="checkbox"/> Unknown at this time <i>If completing CSR, do not complete this section.</i>							
Admission Date	D/C Date	Facility	Reason for Admission	Outcome	Description of treatment		
<b>Prior <u>Outpatient</u> Treatment:</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (Complete history include <u>Substance</u> and Behavioral Health)							
<input type="checkbox"/> Unknown at this time <i>If completing CSR, do not complete this section.</i>							
Admission Date	D/C Date	Facility	Reason for Admission	Outcome	Description of treatment		
<b>Alcohol and Drug Use:</b> (Include all drugs of abuse) <i>If completing CSR, do not complete this section.</i>							
Substance	Age First Used	Age of Regular Use	Date Last Used	Amount	Rate of Use Over Past 6 mo.	Method	

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<b>Patient Name:</b>				
<b>Diagnosis</b>				
Axis I:				
Axis II:				
Axis III:				
Axis IV: Psychosocial and Environmental Problems: (check all that apply)				
<input type="checkbox"/> Problems with primary support group (Specify):				
<input type="checkbox"/> Problems related to the social environment (Specify):				
<input type="checkbox"/> Educational problems (Specify):				
<input type="checkbox"/> Occupational problems (Specify):				
<input type="checkbox"/> Economic problems (Specify):				
<input type="checkbox"/> Problems with access to Health Care Services (Specify):				
<input type="checkbox"/> Problems related to interaction with the legal system (Specify):				
<input type="checkbox"/> Other psychosocial and environmental problems (Specify):				
Axis V Diagnosis: CAF _____ HAF _____				
<b>Family Support System:</b>				
Person	Relationship	Description of Support	Treatment Involvement	Support Level
<b>Prescription Medications:</b> (provide current and history)				
Drug Name	Dosage	Diagnosis	Date Started/Discontinued	
<b>Symptoms Requiring Current Level of Care:</b> Court Ordered <input type="checkbox"/> Yes <input type="checkbox"/> No				
Symptom	Date Started	Most Recent Date	Intervention	Effectiveness (For CSR or Retro)

<b>Patient Name:</b>				
<b>Precautions:</b> <input type="checkbox"/> Suicide <input type="checkbox"/> Seclusion <input type="checkbox"/> Elopement <input type="checkbox"/> Other (specify):				
Explain Precautions:				
Chronic Behaviors	Date First Started	Most Recent Date	Intervention	Effectiveness
<b>Describe treatment plan goals and dates of plan changes:</b>				
Goal	Start Date	Frequency	Intervention	Progress/Status
<b>Motivation and Stage of Readiness (describe):</b>				
<b>Service intensity: For CSR provide total interventions since last review. For Retrospective provide all totals.</b>				
MD Visits:	Individual Therapy:	Family Therapy:	Group Therapy:	
Other (specify):				
<b>Date of most recent evaluation by psychiatrist:</b>				
Identify key findings from evaluation:				
<b>Diagnostic Laboratory Test completed (include date and findings):</b>				
Lab Type	Date completed	Findings		
<b>Additional Comments:</b>				
<b>I affirm all information provided is a true and accurate description of the above named individual.</b>				
<b>Signature:</b>			<b>Date:</b>	

Complete online at [www.pasrr.com](http://www.pasrr.com)  
 Or  
 Fax to DDM at 877-431-9568  
 Attn: ND Under 21 Reviewer