**Inpatient Psychiatric**

**PA Information**

1. Provider Contact Name:
2. Provider Contact Number:
3. Is This a Retro Review: Yes / No.
   1. If Retro Request, date notified of Medicaid eligibility:
4. Presenting Signs and symptoms, including specific behaviors and homicidal or suicidal attempt or ideation.
5. Please Describe Any Acute Mental Status Change(s):
6. Provide a Brief History of Current Illness( How Long Has Patient Been Symptomatic and What Is Patient’s Baseline):
7. Please List Co Morbid Conditions:
8. Is the patient a TDO: Yes / No

If Yes - Date of Hearing:

1. Was a Drug/ETOH Screen Performed: Yes / No

If Yes - Results:

1. Does The Patient Have a Substance Abuse History: Yes / No

If Yes, Provide Date of Last Use:

1. Prior to Admission Has the Patient Been Receiving Outpatient Psychiatric Treatment: Yes / No
2. Prior to Admission Was The Patient Receiving Psychotropic Medications: Yes / No

If Yes - Please List:

1. Please List ALL Psychotropic Medications Ordered on Admission:
2. Please List Any Severe Psychiatric Medication Reactions:
3. Does the Patient Meet With the Psychiatrist Daily: Yes / No
4. Please List the Number of Groups The Patient is Currently Participating In Per Day:
5. Please Indicate How Often Family Therapy Is Occurring:
6. Please List Any Safety Risks:
7. List Current Precautions (Locked Unit, Q 1 Hr Checks Etc):
8. Did This Patient Transfer From Another Unit or Facility: Yes / No

If Yes- List Dates of Prior Stay In Unit Or Facility:

1. For freestanding “0093” Facility Provide The Following Information:

Name of Pre-Screener:

Date of Pre-Screening:

Locality:

1. Please Describe Any Other Pertinent Information Related to This Srv Auth Request: