Health Net Federal Services, LLC

Residential Treatment Center (RTC) Concurrent/Discharge Review

Please complete the review below and submit via fax to 1-844-818-9289.

Additional information may be requested based on the clinical information provided. All fields below must be completed. Please attach the most recent 30 days of family therapy session notes and two weeks of physician progress notes. A copy of the treatment plan and initial psychiatric assessment must be submitted before the first review.

Date: _____ Patient: _____ Reference number/Sponsor ID: _____

Reviewer name: _____ Phone number: _____

Attending MD: _____ Phone number: _____

Current clinical presentation to include behaviors on unit, participation in groups/activities, areas of progress/weakness, program infractions, seclusions/therapeutic holds/time outs:

_____

_____

_____

_____

_____

Family participation to include dates of family therapy (on site and Geographically Distant Family Therapy) and topics discussed:

_____

_____

_____

_____

_____

Current medications/medical problems to include any medication changes since last review, medical appointments, significant lab values, X-rays, weight gain/loss of greater than five pounds:

_____

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_____

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Residential Treatment Center (RTC) Concurrent/Discharge Review *(Continued)*

Treatment plan revisions to include any factors which impede progress:

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_____

_____

_____

Discharge planning to include tentative discharge date, community resources, and/or Department of Social Services involvement:

_____

_____

_____

_____

Discharge Disposition: ☐ Home with parent(s) ☐ Home with guardian/relative (Specify: _____)

☐ Other: _____

Anticipated level of care: ☐ Outpatient ☐ Inpatient ☐ PHP ☐ IOP ☐ Other community resources

If the patient is scheduled for discharge within the next 45 days, complete the following:

Tentative discharge date: _____

Outpatient therapist

Name	Appointment date/time	Address/Phone number

Outpatient psychiatrist

Name	Appointment date/time	Address/Phone number

PHP

Name	Appointment date/time	Address/Phone number

IOP

Name	Appointment date/time	Address/Phone number

Note: Concurrent review by the care manager will occur after receipt of the information above.

Justification for additional days:

_____

_____

_____

_____

Describe any injury, suicide attempt, physical aggression towards peers/staff or elopement and interventions taken:

_____

_____

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