PMIC Continued Stay Review

NAME: ____________________________
DOB: ____________
Date: ____________
Admission Date: ____________
Axis I: ____________________________
Axis II: ____________________________
Axis III: ____________________________
Axis IV: ____________________________
Axis V: ____________________________

Member ID#: ____________________________
Therapist/Doctor: ____________________________
Facility Name:____________________________
Provider Phone #: ____________________________

Form completed by:____

Please fax to: 515-376-9014 or email to case manager.

Current Symptoms/Behaviors within last 24 hours unless otherwise indicated

Place check in box if applicable to patient and explain in detail at bottom of page. Attach an extra page if necessary.

Suicidality:
Not Present:
Ideation:
Plan:
Means:
Attempts (w/in last 72 hrs.):

Homicidality:
Not Present:
Ideation:
Plan:
Means:
Attempts:

Self-Mutilation:
New Onset:
Increase (w/in last 72 hrs.):

Medication Non-Compliance:

Fire Setting (w/in last 48 hrs.):
Assaultive or Threatening:
Impulsive or Agitated:
Sexually Inappropriate:
Impaired Nutrition:
Mental Status Changes:
Medication Reaction:

Destruction of Property:
Unable to Follow Instructions:
Verbal Hostility:
Hallucinations:
Elevated Mood:
Delusions/Illusions:
Decreased Energy:

Decreased Mood:
Hyperactivity:
Anxiety/Panic:
Oppositional:
Current Substance Abuse:
Contraband Found in Patient 's Possession:

Treatment Plan

Precautions:
PRN Medication (at least 2x/24 hr.):

Locked Seclusion:
Physical Restraint (for at least 5 min/2x. Give detail below):

Meds. Changed in Last 48 hrs.:
Seclusion/Room Restriction (for at least 2 hrs.):

Recent changes in treatment plan:

Current Medications (list below):

Explanation of checked boxes (above).

(Attach an extra page if necessary.)

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