Cornerstone Behavioral Healthcare

Continued Stay Review- Outpatient Therapy and Substance Abuse

***Please complete all items. Kepro will not accept without all items answered. ***
***ITP on file must reflect short-term and long-term goals with target dates in the future. ***

Client Name:_____ Client ID#:_____

Provider Name: _____Diagnosis: _____ CSR Date: _____

Type of Service:

- **Therapy**
  - Office and/or telehealth
  - Therapy Community - ITP required at time of request, documenting clinical need for services outside of office or telehealth.
  - Group
- **Substance Use**
  - Office and/or telehealth
  - Community - ITP required at time of request, documenting clinical need for services outside of office or telehealth.
  - Group
- **Medication Management**

Frequency of service: _____

Number of quarter-hour units needed for next six months, or through discharge if discharge expected sooner _____

OR

Expected number of sessions for next six months _____ x expected duration per session _____

Clinical Presentation

- Is this request a new treatment/episode of care?
  - Yes
  - No

- Please discuss member's current presentation; symptoms, and behaviors (frequency, intensity, and duration) that support the level of care request at this time:

- Provide a description of how the provider will use the requested units (breakdown of units) in this requested review period:

- What has been the progress toward goals? (Select only one):
  - None
  - Minimal
  - Moderate
  - Significant
    - If None or Minimal, please provide barriers to progress, and interventions planned to overcome barriers:

- Is member engaged in treatment?
  - Yes
  - No
    - If No, describe the barriers to engagement, and interventions planned to overcome barriers:

- What is the date of the most current diagnostic assessment? _____/_____/_____

- Are there any medication changes since last request?
  - Yes
  - No
    - If yes, please explain:

- What are the symptoms since last review? Select all that apply.
  - Activities of Daily Living (ADL)
  - Aggression
  - Agitation
  - Appetite Impairments
  - Auditory Hallucinations
  - Capacity for Independent Living
  - Delusions
  - Has met pharmacological criteria of substance use
  - Homicidal ideation
  - Learning
  - Impaired control regarding substance use
  - Memory Impairment
  - Mobility
  - Mood Swings
  - Paranoia
  - Physical Aggression
  - Problem Sexualized Behaviors
  - Racing Thoughts
  - Risk/Danger to others

- Risk/Danger to self
- Risky use of substances
- Self-Care
- Self-Direction
- Sensory Hallucinations
- Sleep impairments
- Social impairment regarding substance use
- Suicidal Ideation
- Understanding and use of Language
- Verbal Aggression
- Visual Hallucinations

Discharge Planning

A discharge plan should include a specific plan to decrease utilization, refer to appropriate level of care, and indicate the use of natural supports.

- What is the discharge/transition plan (explain measurable criteria for discharge or decrease in utilization of units)?

- What is the projected discharge/transition date? _____/_____/_____

General

- Select the member's current living situation (Select only one):
  - Assisted Living Facility
  - Community Residential Facility
  - Dorothea Dix
  - Foster Care
  - Homeless shelter or on the Streets
  - Hospitalized for Medical Reasons
  - Incarcerated in a State Prison or County Jail
  - Nursing Home
  - Other Psychiatric Inpatient Unit or Facility
  - Own Apartment or Home
  - Residential Crisis Unit
  - Residential Treatment Facility (Group Home Arrangement)
  - Riverview Psychiatric Center
  - Supported Apartment
  - Temporarily staying with others

- Select the member's current vocational/employment status (Select only one):
  - Clubhouse Transitional Employment
  - Competitively employed full-time (32 or more hours per week)
  - Competitively employed part-time (Less than 32 hours per week)
  - Not employed - looking for work
  - Not employed - not looking for work
  - Self-employed
  - Stay-at-home parent of a child under the age of 18
  - Student
  - Volunteer
  - Working with supports full-time (32 or more hours per week)
  - Working with supports part-time (less than 32 hours per week)

- Is this member of transition age (16-20 years)?
  - Yes
  - No
    - If yes, please complete remainder of section. If no, skip to next section.
- What is member's current grade level? (Select only one)
  - 9
  - 10
  - 11
  - 12
  - College
  - Technical College
  - Not in School
    - If client is not in school, what was last grade completed before leaving school? _____
- In the past three (3) months, has attendance at school been an issue for this member? (Select only one)
  - Yes
  - No
- Was this member involved with the Department of Corrections within the past six (6) months?
  - Yes
  - No

- If member has a guardian, is the guardian engaged in treatment?
  - Yes
  - No
  - N/A
    - If No, describe barriers to engagement:
- Does the member require an interpreter?
  - Yes
  - No
    - If yes, what language and dialect will the interpreter need to know?

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Please provide additional information below to support request for services. Include clinically relevant materials not covered above concerning ongoing treatment and how goals are progressing: (Narrative is typed into Kepro by CBH staff, so brevity is appreciated. Add additional page if needed.)