

Behavioral Health Inpatient Extended Stay

I. Identifying Information:		Medicaid #:	Date: / /
Last Name:	First Name:	Middle Initial:	
Date of birth: / /	Age: Sex:	Date of Admission: / /	Time:
Facility name:	Provider#:	Name of Contact Person	
Commitment type:	Effective Dates	County	Judge
Referral source: () Admitting MD () MH professional () DPRS () Other (list):			
Name of admitting physician:			
IIA. Current status of primary symptoms that require continued acute hospital care:			
(Include: 1. Date of most recent occurrence; 2. Frequency; 3. Duration; 4. Severity)			
IIB. Other relevant clinical information, about patient from past 72 hours:			
(Attach additional pages or documents, as necessary)			
IIC. Current Psychiatric medications (include total daily dose) Also list Start date and or adjustment date:			
IID. Discharge criteria:			
1.			
2.			
3.			
IIIE. Describe treatment, contacts, plans (including outcome) with family, school, etc			
III. Admitting diagnosis (Axis I):			
IV. Additional diagnosis (Axis II):			
Diagnosis (Axis III):			
Diagnosis (Axis IV):			
IV. Functional assessment scores (DSM IV):		AXIS V: (GAF)	
VI. After care plan:			
Provider or facility:			
Signature:			Date:

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