Acadiana Treatment Center

PRTF Application

Date:	Insurance:
PRTF Authorization Status: ☐ Approval Received ☐ Submitted/Awaiting Approval ☐ Accepting Facility to Complete	
Referral Source: ☐ Insurance ☐ DCFS ☐ Parent ☐ OJJ ☐ Hospital, specify: _____ ☐ Other: _____	
Referral Contact Name/Information:	
Where is the youth currently residing at the time of PRTF submission: ☐ Hospital ☐ Home Setting ☐ Detention ☐ Other	

Background Information

Youth Name:	DOB:	Age:
Youth Emancipated: ☐ Yes ☐ No	Youth Married: ☐ Yes ☐ No	Does the youth have a child? ☐ Yes ☐ NO
Address :		
Guardian(s):	Is another guardian involved in treatment? ☐ Yes ☐ No	
Phone 1:	Phone 2:	
Does the other guardian agree with placement? ☐ Yes ☐ No	Explain:	
Legal Status: ☐ State Custody ☐ Parent Custody: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Single Custody ☐ Joint Custody Explain:		
DCFS/OJJ custody: ☐ Yes ☐ No	DCFS/OJJ involvement: ☐ Yes ☐ No	
Parish:	Caseworker Name/Number:	
Does the client receive SSI Benefits? ☐ Yes ☐ No	Guardian informed of potential stop of SSI benefits? ☐ Yes ☐ No	Guardian willing to proceed with admit? ☐ Yes ☐ No

Documentation Checklist- Provide the following with application.

Hospital Records			
	Release of Information		Certificate of Need – Expiration Date:
	Psych Evaluation – Date Completed:		Psychosocial – Date Completed:
	H&P		MD Orders
	Current MD / Psych / Therapy Notes		Current Labs
	Current MAR		
	Discharge Summary, Previous Inpatient Records – Include Diagnosis, MAR, Sig: Medical/Psych/Beh/Cog/Intellectual		
Home Records			
	Immunization Records		Client Social Security Card
	Client Birth Certificate		Parent / Legal Guardian ID
	State Custody Documents / Court Order		
	IQ Testing	Date:	Full Scale IQ:
	SPED Ruling/Edu. Hx (IEP or 504)	School:	Ruling:
	Primary Insurance Card	MCO:	ID#: Ver:

	☐ Louisiana Healthcare Connections ☐ Healthy Blue ☐ Aetna BH ☐ Amerihealth ☐ UHC Community			
	Secondary Insurance Card	MCO:	ID#:	Ver:

Youth Information		
Race/Ethnicity:	Gender: ☐ Male ☐ Female	Gender Expressed: ☐ Male ☐ Female
Height:	Weight:	
Allergies: ☐ NKDA ☐ PCN ☐ Sulfa ☐ Latex ☐ Codeine ☐ NSAIDs ☐ Seafood ☐ Nuts ☐ Fruits: ☐ Other:		
Youth's Living Arrangement	☐ Parents ☐ Group Home ☐ Foster Home ☐ Detention ☐ Other:	
DCFS/OJJ/DHH/PRI Name:	Email:	

Name the adult(s) that have custody of the member. Include custody order if necessary.

Person	Name	Rights?	Phone #:	Supportive:
Father		☐ Yes ☐ No		☐ Yes ☐ No
Mother		☐ Yes ☐ No		☐ Yes ☐ No
		☐ Yes ☐ No		☐ Yes ☐ No
		☐ Yes ☐ No		☐ Yes ☐ No

Psychiatric History			
Why is admission into a PRTF required at this time?			
HX of Suicidal Ideations: ☐ Yes ☐ No	HX of Suicide Attempts: ☐ Yes ☐ No	HX of Self-Injury: ☐ Yes ☐ No	
Describe history self-harm behaviors and dates.			
HX of Homicidal Ideations: ☐Yes ☐No	HX of Homicide Attempts: ☐Yes ☐ No	HX of Fighting/Violence: ☐Yes ☐No	
Describe HX of harm to others. Behaviors and dates.			
HX of Harming Animals: ☐ Yes ☐ No	HX of Starting Fires: ☐ Yes ☐ No	HX of Running Away: ☐ Yes ☐ No	
Describe any of the above noted history.			
HX of Acting Out Sexually: ☐ Yes ☐ No	Abuse HX: ☐Sexual Abuse ☐Physical Abuse ☐Emotional Abuse ☐Neglect		

Describe any of the above noted history.	

Exposure to DV: ☐Yes ☐No	Exposure to Pornography: ☐Yes ☐No	Exposure to Adult Sexual Behavior: ☐Yes ☐ No
Sexual Maladaptive Behaviors: ☐Yes ☐No	Victim of a Crime: ☐Yes ☐No	

Describe any of the above noted history.	
Other behaviors, needs, or activities that put CL at risk?	

Information on Current Placement

Current Placement:	Length of Current Placement:

Current Behavioral Issues	☐ Suicidal Ideations	☐ Suicide Attempt	☐ Self-Harm
	☐ Homicidal Ideations	☐ Aggression towards Others	☐ Violence towards Others
	☐ Verbally Aggressive	☐ Destruction to Property	☐ Defiant Behaviors
	☐ Attempts to Elope	☐ Medication Noncompliant	☐ Refusing Groups
	☐ Visual Hallucinations	☐ Auditory Hallucinations	☐ Other Hallucinations
	☐ Sexually Inappropriate	☐ Poor ADLs	☐ Contraband Items
	☐ Manipulative Behaviors		
	☐ Other:		
Description of Behavioral Issues			

Interaction with Staff		Interaction with Peers	
PRN Meds		Restraints, Holds, and Seclusions	
Codes Required			

Precautions

1:1 ☐Current ☐Last:	LOS ☐Current ☐Last:	Suicide / Self-Harm ☐Current ☐Last:	Aggression ☐Current ☐Last:
Elopement ☐Current ☐Last:	Sexual Acting Out ☐Current ☐Last:	Fall ☐Current ☐Last:	Seizure ☐Current ☐Last:

Redirection	
Response to Redirection:	☐ Responsive Immediately ☐ Responsive After a Period of Time ☐ Non-Responsive
Most Effective Redirection Techniques	☐ Breathing ☐ Coloring ☐ Exercise ☐ Music ☐ Meditation ☐ Journaling ☐ Poetry ☐ Attention from Staff ☐ Relaxation ☐ Medication(s) ☐ Art ☐ Dance ☐ TV / Movies ☐ Puzzles ☐ Time in Room ☐ Walking ☐ Time Outside ☐ Toy / Comfort Item: ☐ Other:
Additional Information	

Substance Use History

Substance	Frequency	Amount	Duration	Last Use	UDS
					+ / -
					+ / -
					+ / -
					+ / -
					+ / -
					+ / -

Mental Health History

Current PSYCH Provider:			Phone #:
Date First Seen:	Date Last Seen:	Frequency: ☐ Weekly ☐ Bi-Monthly ☐ Monthly	Mode: ☐ Individual ☐ Family ☐ Group
Current Counselor:			Phone #:
Date First Seen:	Date Last Seen:	Frequency: ☐ Weekly ☐ Bi-Monthly ☐ Monthly	Mode: ☐ Individual ☐ Family ☐ Group

Provider / Facility	Level of Care	Reason for Tx	Diagnosis
	☐ Inpatient ☐ Outpatient ☐ PRTF		

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	☐ Inpatient ☐ Outpatient ☐ PRTF		
	☐ Inpatient ☐ Outpatient ☐ PRTF		

	Organization	Organization Name	Worker/Manager's Name
Has the child or family received any of the following:	☐ Coordinated System of Care		
	☐ Wrap Around Agency		
	☐ Family Support Organization		
	☐ Healthy Louisiana Case Manager		
	☐ Child and Family Team		
Most Recent Diagnosis:			

Medical History

Physician	Name	Phone #	Date Last Seen
PCP			
Specialist			
Specialist			
Dentist			
Optometrist			
Medical Conditions / Surgeries			

Current Medications

Medication	Dose and Frequency	Compliance	Last Dose Taken
		☐ No ☐ Yes	
		☐ No ☐ Yes	
		☐ No ☐ Yes	

		☐ No ☐ Yes	
		☐ No ☐ Yes	
		☐ No ☐ Yes	
		☐ No ☐ Yes	
		☐ No ☐ Yes	
		☐ No ☐ Yes	
		☐ No ☐ Yes	
		☐ No ☐ Yes	

Female Clients Only				
Onset of Menses:		Difficult/Painful Periods: ☐ No ☐ Yes		# of Pregnancies:
Birth Control	☐ None	☐ Pill	☐ Depo Shot. Date Last Received:	☐ Implant. Placed On:

Sexually Transmitted Disease(s). List Treatment date in box, if applicable.		
☐ HIV / Aids	☐ HPV / Genital Warts	☐ Chlamydia
☐ Hepatitis	☐ Herpes	☐ Syphilis
☐ Trichomoniasis	☐ Gonorrhea	☐ Other:

Educational History	
Last School Attended:	Grade:
School Address:	
Special Accommodations Needed: ☐ IEP ☐ 504 ☐ Other:	
Behavioral Issues Noted in School	

Admission Decision		
Approved for Admission? ☐ Yes ☐ No	Rationale for Denial:	
Person Notified:		
Date of Notification:		
Signature:	Date:	Time: