Letter from the Medical Director:

Thank you for interest in the Psychiatric Research Institute Child Diagnostic Unit (PRI CDU). The need for a System of Care of children’s behavioral health has been identified as a critical priority in Arkansas. Families seeking help for their children often become frustrated and stressed as they navigate their way through the complexity of their child’s school, legal system, and even social service systems. Therefore, we at PRI believe it is time for a “new” and “innovative” idea.

At the University of Arkansas for Medical Sciences PRI CDU, a primary goal is to truly understand a child’s symptoms and their impact on the child and family functioning. Our mission is to provide child and family centered care that is collaborative, humane, and trauma sensitive, subsequently assist in establishing clarification of diagnoses and development of appropriate treatment planning. As the state’s only diagnostic inpatient unit, we use an interdisciplinary approach (psychiatry, psychology, social work, occupational therapy, speech and language, education, nursing, etc.) to assess children ages 2 to 12 years old with a variety of diagnoses. Children considered for admission to the CDU have been unsuccessful in their current outpatient mental health treatment which has created a question of diagnostic clarification.

We believe our interdisciplinary approach will enable us to develop individualized treatment plans for rational (and early) intervention. This approach includes extensive family and/or caregiver involvement including expected participation in weekly family therapy and weekly parent group. Additionally, families/caregivers will receive post discharge case management for 90 days by a Psych TLC mental health professional to integrate CDU treatment plan with community based resources. Other innovative ideas that the CDU provides include an “open hours” visitation policy to encourage families to “partner” in the collaboration of their children, no use of mechanical restraints, and thoughtful use of medication to manage identified psychiatric target symptoms.

The CDU is implementing a new model of care: Collaborative Problem Solving (CPS) originally fashioned by Dr. Ross Greene, a child psychologist at Massachusetts General Hospital. CPS is a method of assisting children and their disruptive behaviors using a cognitive behavioral approach that focuses on how adults interact with children in managing a child’s behavior and collaborating with children to solve problems. CPS operates under the basic premise that “kids do well if they can.” It is a philosophy about kids, and how we help kids.

The staff of the CDU aspires to provide child and family centered care that establishes respectful, nurturing care and rapport which leads to the development of trust and openness. We at the CDU strive to be teachers, role models, astute observers of behavior, and collaborators with children and their families.

For additional referral packet information and processes, please contact Michelle Gillespie, at 501-413-6413 or tmgillespie@uams.edu.

Sincerely,

Dianna Esmaeilpour, MD

Medical Director, PRI Child Diagnostic Unit
Completed Documents Required for CDU Admissions

Please find attached the Child Diagnostic Unit referral packet. Forms may be completed by guardian or mental health provider, but should explain in detail the difficulties and symptoms your child is experiencing. Upon completion, please fax the forms to (501)526-0302; these forms can also be emailed to tmgillespie@uams.edu.

Information provided by the child’s guardian:

☐ Referral Psychosocial Assessment Information
☐ Copy of Guardians Driver’s License
☐ Current treatment plan from mental health provider
☐ Copies of previous testing reports: Psychological, Speech and Language, Occupational
☐ IEP and/or 504 Plan
☐ Medication History (obtained from pharmacy)
☐ EPSDT form (Included in application packet)

*CDU recommendations- When calling your Primary Care Physician let them know it is to have an Early and Periodic Screening, Diagnosis, and Treatment referral. Please be sure to bring the form provided (pg.9) to your doctor’s appointment.

Information obtained from your own personal records or by calling the Arkansas Department of Health (501-661-2169) to obtain a free record:

☐ Immunization Record

Referral and Admissions Contact:

Michelle Gillespie, Program Specialist
UAMS/ Psychiatric Research Institute
4301 W. Markham #554
Little Rock, AR. 72205
Phone (501) 413-6413
Fax: (501) 526-0302
INFORMATION FOR ADMISSIONS
Children’s Diagnostic Unit

Patient Name: ____________________________________  SS#: ________________________________

Address: ___________________________  City: __________________ State: _____ Zip: ____________

DOB: ________________  Race: _______________________

Parent/Guardian: ____________________________  SS#: ________________________________

Address: ___________________________  City: __________________ State: _____ Zip: ____________

Home Phone: ________________  Work Phone: ___________________  Cell Phone: ___________________

Parent/Guardian DOB: ________________  Email address: _________________________________

Teacher Name: ________________________  Phone Number: ________________  School Email: ________________________

Outpatient Therapist Name: ________________________  Phone: ___________________  Email: ________________________

PCP: ________________________  Phone: ___________________  Fax: ________________________

Patient’s Medicaid Number: ________________________

Other Insurance: ________________________  Group #: ________________  Policy #: __________

Admitting Doctor: Esmaeilpour, Dianna  Room: PI 5 5s
Chief Complaint: Behavioral Problems  Estimated LOS: 21 days
DX: V40.3 Behavioral Problems NEC
Psychosocial Assessment

What are the main reasons for desiring admission to the Child Diagnostic Unit? (list in detail dates, times, and events that contributed to this decision)

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

___________________________________

Child Name: _________________________

Guardian: ________________________

Child DOB: ________________________

Guardian DOB: ________________________

Child SSN: ________________________

Guardian SSN: ________________________

Child’s Address: ________________________

Guardian Address: ________________________

State: _______ Zip: __________

County __________

State: _______ Zip: __________

Race/ Ethnicity: [ ] Caucasian [ ] African American

[ ] Hispanic [ ] Native American

[ ] Other: ________________________

Child’s Gender: [ ] Male [ ] Female

Height: _______ Weight: _______

Emergency Contact: ________________________

Address of Emergency Contact: ________________________

Phone Number: ________________________

Relationship: ________________________

What is the Guardian’s Relationship to the Child? ________________________

Child’s legal mother: ________________________ Child’s legal father: ________________________

Were the Biological parents’ rights terminated? [ ] yes [ ] no [ ] N/A (documentation required if yes)

* Where the child’s biological or adoptive parents are not married (separated, divorced, etc.) or custody is legally held by another person(s), a court custody agreement document showing authority to act on the child’s behalf will be required.

I, ________________________, confirm that I am the [ ] biological parent, [ ] the custodial parent, [ ] adoptive parent, [ ] other legal guardian________________________, and that I have authority to consent UAMS Psychiatric Research Institute admission and sign authorizations to release information for________________________ (child’s name). I agree to provide legal documentation to verify this unless I am one of the biological parents. I also agree to inform UAMS PRI if there are changes in legal guardianship. I understand that, under Arkansas Law, a non-custodial parent is entitled to received medical information about his/her child.

___________________________________

Signature of Legal Parent/Guardian

Date

Time

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(Place MR Label Here)
MR#
Patient’s Name:
Patient’s Address:

Is the Guardian employed? [ ] Yes [ ] No If yes, where? ________________________________

Please List the Child’s Insurance.
Provider: ____________________________________________________________________________
ID#: _______________________________________________________________________________

Please list other members of the family living in the home:
Name: ___________________________ Relationship: ___________________ Age: ________________
Name: ___________________________ Relationship: ___________________ Age: ________________
Name: ___________________________ Relationship: ___________________ Age: ________________
Name: ___________________________ Relationship: ___________________ Age: ________________
Name: ___________________________ Relationship: ___________________ Age: ________________

Child’s Medical History:
Child’s Primary Care Physician: ___________________________ Phone number: __________________

Check if Applicable: [ ] Cardiac Problems
[ ] Asthma [ ] Head Injury
[ ] Seizures Other, please explain: ________________________________________________
[ ] Diabetes

Allergies (Food, Drug, etc): _______________________________________________________

List of Current Medications:
Medication: ___________________________ Dose: ___________________________ Side Effects: ______
Medication: ___________________________ Dose: ___________________________ Side Effects: ______
Medication: ___________________________ Dose: ___________________________ Side Effects: ______
Medication: ___________________________ Dose: ___________________________ Side Effects: ______

Child’s Mental Health Symptoms:
[ ] history of suicide attempt [ ] sexually acting out* [ ] trauma*
[ ] history of threatening suicide [ ] delusions/hallucinations* [ ] physical aggression* *
[ ] agitation [ ] hyperactivity [ ] property destruction*
[ ] feelings of hopelessness [ ] depression [ ] fire setting*
[ ] recent family/ friend loss [ ] weight gain/ loss [ ] death in the family
[ ] disruption of support system [ ] self-injury [ ] anxiety
[ ] cruelty to animals [ ] disorganized speech [ ] paranoia
[ ] thoughts of harming others [ ] catatonic behavior
[ ] poor sleep patterns [ ] panic attack

Please explain any items marked on following page.
Explain any items marked with an asterisk, giving details of last incident and any reports to authorities:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**Family Mental Health History:**
- [ ] history of suicide attempt: ____________________________________________________
- [ ] history of threatening suicide: _________________________________________________
- [ ] depression: ____________________________
- [ ] sought therapy in the past: ____________________________
- [ ] delusions/ hallucinations: ____________________________________________________
- [ ] loss or disruption of support system: ___________________________________________
- [ ] feelings of hopelessness: _____________________________________________________
- [ ] seen psychiatrist in past: _____________________________________________________
- [ ] other, please explain: _______________________________________________________

Is there a family history of drug and/or alcohol abuse?  [ ] yes [ ] no

Explain any YES answers (who/ what/ when): _______________________________________

Has the child used drugs or alcohol?  [ ] yes [ ] no

If YES, What age: ________ How Often: ________ What Substance: _______________________

**Parent’s discipline methods:** (check all that apply)
- [ ] time out  [ ] other: ____________________________
- [ ] spanking  [ ] send to room
- [ ] take away privileges

**Family Environment:**
- [ ] divorce/ separation  [ ] recent death  [ ] recent birth  [ ] family violence
- [ ] family member illness  [ ] unemployment  [ ] gang activity  [ ] financial problems
- [ ] recent relocation  [ ] family incarceration  [ ] other: _______________________

**Does your child have special needs? :**
- Sensory: [ ] yes [ ] no  Enuresis (bed wetting): [ ] yes [ ] no
- Motor: [ ] yes [ ] no  Encopresis (fecal soiling): [ ] yes [ ] no
Has your child ever received these services?

Speech therapy: [ ] yes [ ] no
What age did your child sit alone: ___________
If yes, Agency: ____________________________
Length of time ____________________________
What age did your child walk alone: ___________
What age did your child speak their first word: ____________

Occupational therapy: [ ] yes [ ] no
What age did your child say 2-3 word phrases: ____________
If yes, Agency: ____________________________
Length of time ____________________________
Physical therapy: [ ] yes [ ] no
Can your child: [ ] Dress self [ ] toilet self
If yes, Agency: ____________________________
Length of time ____________________________
[ ] Bath self [ ] feed self
Is your child nonverbal? [ ] Yes [ ] no
Is your child hearing impaired? [ ] Yes [ ] no
(If yes, how does your child communicate?)

Mental Health History:
Date of last psychological testing: ____________
Agency: ____________________________
List your child’s previous diagnoses: (ADHD, ODD, PTSD etc.)
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Treatment History: (Starting from Current) Child must currently be enrolled in outpatient therapy.
Prior Outpatient Treatment: (Including school-based and day treatment)

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<th>Facility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Reason of Admission</th>
<th>Outcome</th>
<th>Therapist, phone number</th>
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Prior Inpatient Treatment: (including residential care)

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Other Placements: (foster care, group home, shelter, detention, boot camp, etc.)

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Current Level of Care:

**Outpatient:** [ ] yes [ ] No  Clinic: __________________________
Therapist: __________________ Phone: ___________________________ Psychiatrist: _____________________________

**Inpatient:** [ ] yes [ ] No  Clinic: __________________________
Therapist: __________________ Psychiatrist: __________________ Phone: _____________________________

**Day Treatment:** [ ] yes [ ] No  Clinic: __________________________
Therapist: __________________ Psychiatrist: __________________ Phone: _____________________________

Legal History:
Has the Child ever been in the custody of DHS or Social Services? [ ] yes [ ] no  Reason for custody placement: ____________________________________________

If currently in DCFS custody, can child return to current placement? [ ] yes [ ] no
If no, has placement been identified? [ ] yes [ ] no  Where: ____________________________
Name of Caseworker: __________________ Phone: _____________________________

Does Child have a FINS petition? [ ] yes [ ] no  If yes, provide a copy.
What is the name and contact information of the FINS officer? _______________________________________

School Information:
Current School: __________________ Grade: ________ Teacher: ____________________________
Teacher Email: ____________________________

Phone Number_________________________

Classroom Type: [ ] Regular [ ] Self-contained [ ] Resources Classes [ ] ALE

Does the Child have a(n): [ ] IEP [ ] 504 (Please provide a copy)

Does your child have friends or play with other children? [ ] yes [ ] no

Extra-Curricular activities: ____________________________________________

Check problematic behavior’s in school:
[ ] tardy often  [ ] absenteesim  [ ] repeated grade
[ ] disruptive [ ] skipping classes [ ] poor performance
[ ] social problems [ ] defiance [ ] suspended/expelled
Psychiatric Research Institute Early and Periodic Screening, Diagnosis & Treatment (EPSDT)

PRESCRIPTION/ REFERRAL

For Medically Necessary Services/ Items not specifically included in the Medicaid State Plan
The primary care physician (PCP) must use this form to prescribe medically necessary services resulting in an EPSDT screen when the services are not specifically included in the Arkansas Medicaid State Plan. Please refer to Section 1 of your Arkansas Medicaid Child Health Services (EPSDT) manual for a list of covered services. Early and Periodic Screening, Diagnosis and Services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. EPSDT covers any medically necessary service that will lead to the maximum reduction of medical and physically disabilities and restore the child to his or her best possible functional level. Services that are necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be considered for and EPSDT beneficiaries under 21 regardless of whether the service is otherwise included in the Arkansas Medicaid State Plan for this patient.
The PCP must check the appropriate box or boxes and complete and sign the form. A copy of the EPSDT screen results (form CMS-1500) may be attached.

[ ] Prescription/ Treatment  [ ] Referral

Patient Name: Medicaid ID #: ____________________________________________

Date of Last Physical Examination: _______________________________________

Medical Diagnosis: _______________________________________________________

Developmental Diagnosis: _________________________________________________

Other Diagnosis: _________________________________________________________

Prescribed Treatment: Inpatient evaluation and observation is medically necessary in order to accurately diagnose and/ develop a treatment plan for this patient.

________________________________________  __________________________________
Primary Care Physician Name (Please Print)  Provider Identification Number/ Taxonomy Code

By signing as the primary (PCP), I hereby certify that I have carefully reviewed the EPSDT screen results, and that the goals are reasonable and appropriate for this patient. If this prescription is for a continuing plan, I have reviewed the patient’s progress and adjusted the plan based on his or her meeting, or failing to meet, the plan goals.

________________________________________  ________________________________  ______________
Primary Care Physician (PCP) Signature  Date  Time

Please contact Michelle Gillespie, Program Specialist for any questions (501)-413-6413.

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