A Letter from the Medical Directors

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 care giver 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 Stacy Henderson at (501) 526-8502 or SHenderson3@uams.edu.

Sincerely,

Toby Belknap, M.D., and Molly Reeves, M.D.

Medical Directors, PRI Child Diagnostic Unit

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS | Psychiatric Research Institute

Information for Admission to Child Diagnostic Unit

Date:________________

Patient Name:________________ SS#__________

Address:________________ County:__________

City:________________ State:____ Zip:__________

DOB:__________ Age:____ Race:__________

Gender: ____ Preferred Gender: ____ Height:____ Weight:____

Patient's Medicaid #:________________

Other Insurance:________ Group #:________ Policy #________

Person filling out Application Packet: ________________

Relationship to patient: ________________

Parent/Guardian:________________ SS#__________

Parent/Guardian:________________ SS#__________

Address:________________

City:________________ State:____ Zip:__________

Phone #:________________ Phone #:________________

Parent/Guardian DOB:__________ Email Address:__________

Who referred patient to CDU?________________

Outpatient Psychiatrist and Clinic: ________________

Outpatient Therapist: __________ Outpatient Therapist #__________

PCP:__________ PCP#:__________ PCP Fax #__________

Admitting Physician: Dianna Esmaeilpour - Chief Complaint: Behavioral Problems
DX: V40.3 Behavioral Problems NEC - Room: PI 5 5s Estimated LOS: 28 Days

(Place MR Label Here)
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Psychosocial Assessment

What problems has the child been having?

____

____

____

____

____

____

____

Are you seeking admission due to a current court order? [ ] yes [ ] no

What are your goals for admission?

____

____

____

____

Child's Mental Health History

Any previous Psychological Testing? _______ If so when? ___________________

By whom? ____

Past Psychiatric Diagnoses: ____

____

Child's Mental Health Symptoms:

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

Please explain any starred (*) items: ____

____

____

____

____

____

____

Prior **Outpatient** Treatment: (Including school-based and day treatment)

Facility	Start	End	Reason for Treatment	Therapist Name, Phone Number

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Patient's Date of Birth:

Prior **Inpatient** Treatment: (including acute or residential care)

Facility	Start	End	Reason for Admission

What is the child's current living situation? ______________________________

____

Child's Legal Parent:______________________________
Child's Legal Parent:______________________________
Have parental rights been terminated from either parent? Mother: [ ] yes [ ] no Father: [ ] yes [ ] no
If you are not the child's parent, describe your relationship to the child: ______________

____

Custodians or guardians must provide documentation to verify authority to act on behalf of the patient and agree to inform UAMS PRI of any changes in status during the course of treatment.

I, ______________________, confirm that I am the [ ] biological parent, [ ] custodian, [ ] adoptive parent, [ ] or other legal guardian of ______________________, and I have legal authority to consent to his/her admission at UAMS Psychiatric Research Institute.

______________________ ______________ ______________

Signature of Parent/Custodian/Guardian Date Time

Please list all of the individuals living in the primary home setting:
Name: ______________________Relationship:______________Age: ______
Name: ______________________Relationship:______________Age: ______
Name: ______________________Relationship:______________Age: ______
Name: ______________________Relationship:______________Age: ______
Name: ______________________Relationship:______________Age: ______
Name: ______________________Relationship:______________Age: ______
Name: ______________________Relationship:______________Age: ______
Name: ______________________Relationship:______________Age: ______

Describe any special custody/ visitation issues that we need to consider during the child's stay, such as court ordered visitation, limited phone calls, orders of protection, no contact orders, etc.: ______________

____

____

Does anyone close to the child have legal limitations from interacting with other children? [ ]yes [ ]no
Where does the child typically sleep? ______________________________
With whom do they share a room? ______________________________
With whom do they share a bed? ______________________________
Has the child used drugs or alcohol? [ ] yes [ ] no [ ] unknown

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Family Environment:

[ ] divorce/ separation [ ] recent death [ ] recent birth [ ] family violence
[ ] family member illness [ ] unemployment [ ] gang activity [ ] financial problems
[ ] multiple moves [ ] family incarceration [ ] family member with substance abuse
Other: ____________________

Academic Information:

School:____Grade:________________________
Teacher: ___________________________ Teacher's #: _______________________________
Teacher Email: _______________________
Current Classroom Type: [ ] Regular [ ] Self-contained [ ] Resource [ ] ALE [ ] Day Treatment
Past classroom settings: [ ] Self-contained [ ] Resource [ ] ALE [ ] Day Treatment
Current Academic Performance/ Grades: [ ] A's [ ]B's [ ]C's [ ]D's [ ]F's [ ] not applicable
Does the child have a(n): [ ] IEP [ ] 504 (Please provide a copy)
Has the child repeated a grade? [ ] yes [ ] no Which grade?______________________________
Does the child have a personal aide at school? [ ] yes [ ] no [ ] part of the day: _______________
Does the child have friends at school? [ ] yes [ ] no ______________________________________
Extra- Curricular activities: ____
Check problematic behaviors in school:

[ ] tardy often [ ] aggression [ ] repeated grade
[ ] disruptive [ ] skipping classes [ ] poor performance
[ ] problems with peers [ ] defiance [ ] suspended/ expelled
[ ] meltdowns [ ] work refusal [ ] problems on the school bus
[ ] difficulties with transition [ ] won't stay seated [ ] talks excessively
Other:____

Legal History:

Does the child have a FINS petition? [ ] yes [ ] no If yes, provide a copy.
What is the name and contact information of the FINS officer? ____________________________
Has the child ever been in the custody of DHS or Social Services? [ ] yes [ ] no
Reason for custody placement: ____
Estimated dates in DCFS custody? ____
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: ______________________________

Child's Medical History

Medical problems: ____
Allergies (Food, drug, environmental):____
Please check if the child has a history of any of the following:

[ ] Premature birth _____ weeks [ ] Lice: last treatment ___________
[ ] Multiple ear infections [ ] Flu in the last year [ ] Constipation
[ ] Severe Strep throat [ ] Feeding difficulties [ ] Seizures
[ ] Broken Bones [ ] Severe injury [ ] Severe head injury
[ ] Prenatal drug or alcohol exposure [ ] Multiple medical hospitalizations

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List of Current Medications:

Medication: ______________________________Dose: ____________________
Medication: ______________________________Dose: ____________________
Medication: ______________________________Dose: ____________________
Medication: ______________________________Dose: ____________________
Medication: ______________________________Dose: ____________________
Medication: ______________________________Dose: ____________________

Special Needs:

Does the child have trouble seeing or wear glasses? ______________________________
If the child wears glasses, do they have difficultly seeing distance or reading? ______________
Does the child have trouble hearing or wear a hearing aid?______________________________
Does the child have trouble speaking or use a communication device?____________________
List any concerns you have about the child's hearing, vision or speaking: ________________
____

*Please bring glasses, hearing aids or other devices the child uses.
Does the child speak English?_________ What other languages are spoken in the home?____________

Has the child ever received:

Speech Therapy? [ ] yes [ ] no — Currently Receiving [ ] Previously Received [ ]
Location: ____________________Estimated Dates: ____________________
Physical Therapy? [ ] yes [ ] no — Currently Receiving [ ] Previously Received [ ]
Location: ____________________Estimated Dates: ____________________
Occupational Therapy? [ ] yes [ ] no — Currently Receiving [ ] Previously Received [ ]
Location: ____________________Estimated Dates: ____________________

Does the child have any sensory issues (such as limited food eaten, bothered by clothing tags or seams, dislikes haircuts, dislikes loud noises or bright lights, etc.)?______________________________
____

Does the child have difficulty with motor coordination (buttons, zippers, tying shoes, riding a bike, poor handwriting)? ____
____

Check if the child can do the following:

[ ] Dress self [ ] Toilet self [ ] Bathe self [ ] Feed self

Does the child wear diapers? [ ] yes [ ] no If yes, when? [ ] Day [ ] Night
Does your child have frequent accidents with [ ] urine and/or [ ] feces? [ ] yes or [ ] no
Do accidents occur [ ] daily [ ] or on occasion?

Is there any other information that we need to know about the patient?
____
____
____
____

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MR#:
Patient's Name:
Patient's Address:

PRI Early & 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 from 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 Treatment (EPSDT) is defined as follows: a benefit provided for screening, vision, hearing and dental 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 physical 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 EPSDT beneficiaries under age 21 regardless of whether the service is otherwise included in the Arkansas Medicaid State Plan. Inpatient evaluation and observation is medically necessary in order to accurately diagnose and/or develop a treatment 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 DMS-694) may be attached.

[ ] Prescription / Treatment [ ] Referral

Patient Name: Medicaid ID#: ______________________________

Date of Last Physical Examination: ______________________________

Medical Diagnosis: ______________________________

Developmental Diagnosis: ______________________________

Other Diagnosis: ______________________________

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

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

By signing as the primary care physician (PCP), I hereby certify that I have carefully reviewed the EPSDT screen result, 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 Phsycian (PCP) Signature Date Time

Med Rec 1417 (01/10)
Consent