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 send an e-mail to childinpatient@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

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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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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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Patient's Address:

UAMS
PSYCHIATRIC RESEARCH INSTITUTE

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 Treatment: 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 Physician (PCP) Signature Date Time