

Continued Acute Stay in an Inpatient Psychiatric Facility Review Template

The following electronic checklist is to be used by UM staff in the review and approval process for concurrent inpatient hospitalization authorization requests. All boxes must be checked in the respective area in order for the authorization to be approved.

Inpatient Hospitalization Concurrent Authorization Request Review

Met **Not Met**

The patient has one of the following:

- A current DSM-IV, Axis I diagnosis; or
- A current DSM-IV, Axis II diagnosis and current symptoms/behaviors which are characterized by all of the following:
 - Symptoms/behaviors are likely to respond positively to acute inpatient treatment.
 - Symptoms/behaviors are not characteristic of patient's baseline functioning.
 - Presenting problems are an acute exacerbation of dysfunctional behavior patterns, which are recurring and resistive to change.

Comments:

The symptoms are not due solely to mental retardation.

Comments:

The patient's symptoms are characterized by:

- At least one of the following:
 - Endangerment of self or others.
 - Behaviors which are grossly bizarre, disruptive, and provocative (e.g. feces smearing, disrobing, pulling out hair).
 - Related to repetitive behavior disorders which present at least five times in a 24-hour period.
 - Directly result in an inability to maintain age appropriate roles.
- The symptoms of the patient are characterized by a degree of intensity sufficient to require continual medical/nursing response, management, and monitoring.

Comments:

The services provided in the facility can reasonably be expected to improve the patient's condition or prevent further regression so that treatment can be continued on a less intensive level of care, and proper treatment of the patient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

Comments:

A specific discharge plan is in place.

Comments:

Treatment is being provided appropriately and expeditiously.

Comments:

Name and Credentials of Reviewer: _____

Number of days of continued stay authorized: _____

Next review date: _____

Date and Time the decision was rendered and communicated to the facility:

In the space provided below, document any comments, including the rationale for determining the next review date and the rationale for why the requested extension can not be authorized, if the request has been forwarded to a peer reviewer,