Patient Chart # _____

TREATMENT PLAN/ PLAN REVIEW/ DISCHARGE PLAN

Patient Name:_____D.O.B.:_____Est. Discharge Date: _____

After Care Plan: Patient/Family's expectation concerning treatment outcome, community resource referrals, educational activities, and/or other support services to withstand improvements achieved during treatment:

_____

_____

_____

Responsible Behavioral Staff: _____

I, the patient or the patient's guardian reviewed and agreed to participate in the interventions identified in the Individualized Treatment Plan that is in Intecelle Inc. electronic records system (Open EMR). **I HAVE ALSO RECEIVED A COPY OF SAID TREATMENT PLAN FOR MY RECORDS.**

Furthermore, the services can be expected to improve the client's condition and functional level which cannot be improved in a less restrictive or less costly level of care.

☐ **Patient** ☐ **Guardian Signature:** _____ **Date:** _____

Clinician Signature & Credentials: _____ **Date:** _____

Supervisor/Reviewer Signature & Credentials: _____ **Date:** _____

Addt'l Team Mbr. Signature & Credentials: _____ **Date:** _____

As the treating psychiatrist and/or licensed clinician for the above referenced patient; I hereby certify this patient meets the eligibility criteria and needs the behavioral health services as outlined in the Individualized Treatment Plan.

I additionally certify the specific treatment services herein prescribed for the patient in this Treatment Plan is medically necessary and appropriate to the patient diagnosis and treatment will start from the date of admission. Review of this treatment plan will occur at a minimum of every six (6) months.

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INTECELLE
BEHAVIORAL HEALTH SERVICES

Patient Chart # _____

TREATMENT PLAN / TREATMENT PLAN REVIEW

STATEMENT OF MEDICAL NECESSITY

Patient Name:_____ D.O.B.:_____

Please check **ALL** services to be provided for the duration of the Treatment Plan:

	Service Responsible Staff	Frequency Amount per week/month	Duration Months/Year	Available Units	Start Date
	Psychiatric Evaluation **Psychiatrist/ARNP**	Once per year	60 Minutes/ year	4 per year	
	Medication Management **Psychiatrist/ARNP**	Once per Month	30 Minutes/ month	2 per year	
	BBHSE/BMHS **Licensed Clinician**	Once per Admission	60 Minutes/ admission	8 per year 4 per 6 months	
	Bio-Psychosocial/In-Depth Assessment **Therapist**	Once at Admission	60 Minutes/year	4 per year	
	CFARS/FARS **Therapist**	Every 6 Months & Upon Discharge	15 Minutes/ 6 months	2 per year	
	Treatment Plan **Therapist**	Once per year	60 Minutes	4 per year	
	Treatment Plan Review **Therapist**	3 per Year (Quarterly)	180 Minutes/year	12 per year	
	Individual/Family Therapy **Therapist**	Once Bi-weekly	60 Minutes/ session	104 per year 8 per month	
	Group Therapy **Therapist/Counselor**	_____Time per week	___Mins. Per week	156 per year 13 per month	
	TBOSS/H2019HO **Therapist**	_____Time per week	___Mins. per month	36 per month	
	TBOSS/H2019HN **Therapist**	_____Time per week	___Mins. per month	36 per month	
	TBOSS/H2019HM **Counselor**	_____Time per week	___Mins. per month	128 per month	
	Psychosocial Rehabilitation Service **Therapist/Counselor**	_____Time per week	___Mins. per week	1920 per year 160 per month	
	Behavioral Health Day Service **Therapist/Counselor**	_____Time per week	___Mins. per week	190 per year 15 per month	
	Behavioral Health Day Service Substance Abuse **Therapist/Counselor**	_____Time per week	___Mins. per week	190 per year 15 per month	
	Other				

As the treating psychiatrist and/or licensed clinician for the above referenced patient, I hereby certify that this patient is in need of behavioral/mental health services, meets the eligibility criteria, and the specific treatment services herein prescribed is medically necessary and appropriate to the patient's diagnosis as outlined in his/her Individualized Treatment Plan and will be provided by Intecelle Inc. starting from the date of admission.

Psychiatrist/Licensed Clinician Signature Date

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INTECELLE
BEHAVIORAL HEALTH SERVICES

Patient Chart # _____

PHYSICAL HEALTH

PAIN MANAGEMENT SCREENING

Patient Name:_____ D.O.B.:_____ Gender: ☐ Male ☐ Female

Clinician:_____ Admit Date: _____

Date of Last Physical Exam:_____ Health Status: ☐ Good ☐ Poor ☐ Bad

Any Surgical Operations: _____

List ALL medicine that you are currently taking: _____

List any allergies to medications: _____

Describe any serious illnesses (current and/or past):

_____

Are you having any sleeping problems?

_____

Check all problems that may apply to you:

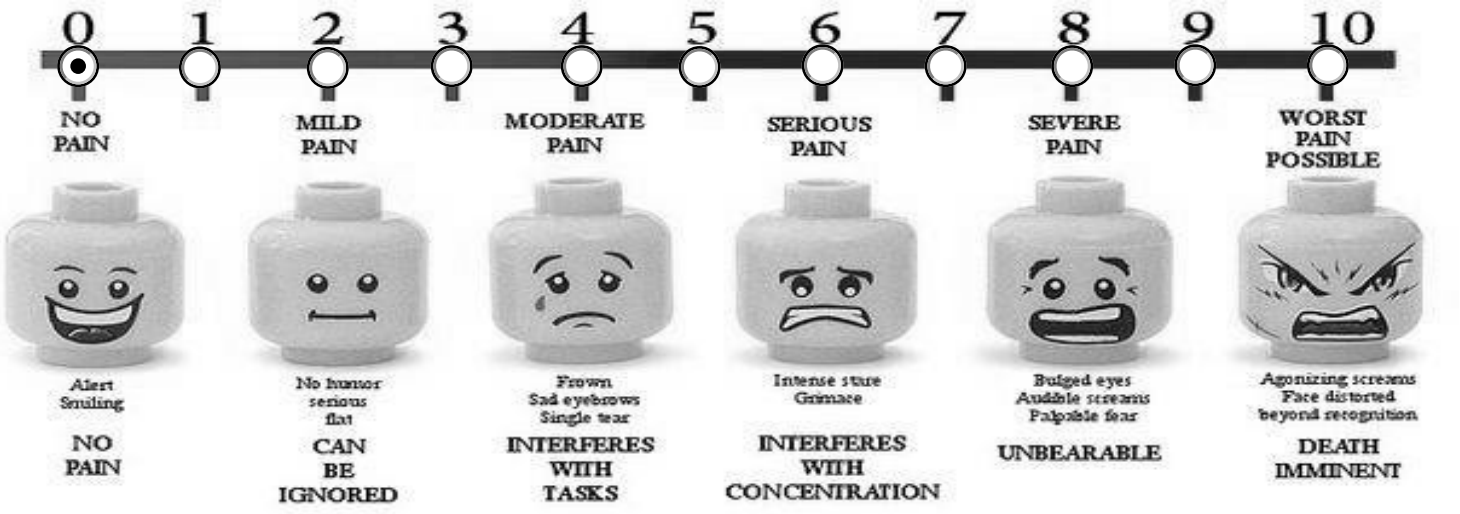
☐ Physical ☐ Learning Disability ☐ Diabetes ☐ Heart ☐ Bleeding ☐ Breathing ☐ Kidney ☐ Headaches ☐ Dizziness Bad

☐ Teeth ☐ Skin Rashes ☐ Back Pain ☐ Joint Pain ☐ Bladder Control ☐ Cancer ☐ Stomach Aches ☐ Seizures Other (List):

☐ _____

PAIN SCALE

This scale is intended to measure how much pain a person is feeling inside. The face and the number correspond to the level of pain. Please pick a number from 0 – 10.



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DRUG & ALCOHOL SCREENING

During the past 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips) (Do not count sips of alcohol taken during family/religious events)	☐	☐
2. Smoke and Marijuana or Hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or huff)	☐	☐
4. Have you ever ridden in a CAR driven by someone else (including yourself) who was high or had been using drugs or alcohol?	☐	☐
5. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
6. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
7. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
8. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
9. Have you ever gotten in TROUBLE while you were using alcohol or drugs?	☐	☐

NUTRITIONAL SCREENING

#	Description	Circle	
1	Is there an underlying illness with risk for malnutrition or expected major surgery?	No ◉	2 ○
2	Is the patient in a poor nutritional status judged with subjective clinical assessment: loss of subcutaneous fat and/or loss of muscle and/or hollow face?	No ◉	1 ○
3	Is one of the following items present? • Excessive diarrhea (≥ 5 per day) and/or vomiting (> 3 times/day) during the last 1-3 days • Reduced food intake during the last 1-3 days • Pre-existing nutritional intervention (e.g. ONS or tube feeding) • Inability to consume adequate nutritional intake because of pain	No ◉	1 ○
4	Is there weight loss or significant increase during the last few week-months?	No ◉	1 ○
	Total *(Max score 5 points)*		

Total your Nutritional Score.

0 Low Risk: No nutritional risk. Recheck your nutritional score in 6 months.

1-3 Moderate Risk: See what can be done to improve your eating habits and lifestyle. Recheck your nutritional score in 3 months.

4-5 High risk: Please follow-up with your primary health care provider or make an appointment with your local health department.

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MENTAL HEALTH SCREENING

Check all answers that may apply. This form is to be filled out by the patient, parent/guardian, or clinician.

	No	Yes
1. I have never been treated for mental or emotional problems.	☐	☐
2. I have been treated in the past.	☐	☐
3. I am currently in treatment.	☐	☐
4. I need mental health help.	☐	☐
5. Do you have trouble paying attention?	☐	☐
6. Do you often:	☐	☐
Feel distrustful of others	☐	☐
Strange thoughts	☐	☐
Hear Voices	☐	☐
Have to do things the same way or keep repeating them	☐	☐
7. Do you have problems in school with:	☐	☐
Behavior	☐	☐
Grades	☐	☐
Skipping Classes	☐	☐
8. Do you worry about your:	☐	☐
Eating	☐	☐
Sleep	☐	☐
Weight	☐	☐
9. Do you have trouble making or keeping friends?	☐	☐
10. Do you often feel :	☐	☐
Sad	☐	☐
Angry	☐	☐
Nervous or Afraid	☐	☐
11. Have you thought about or done any of the following:	☐	☐
Destroy property	☐	☐
Hurt animals	☐	☐
Set fire	☐	☐
Listen to music with violent message	☐	☐
Smoke Cigarettes	☐	☐
Sex without protection	☐	☐
Suicide attempt	☐	☐

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SCALE OF SUICIDAL IDEATION

The scale of suicidal ideation consists of 19 items, scored 0 to 2 each, which can be used to evaluate a patient's suicidal intentions. It can also be used to monitor a patient's response to interventions over time. Higher scores indicate greater suicidal ideation.

Item	Response	Points
1. Wish to live	Moderate to Strong	0
	Weak	1
	None	2
2. Wish to die	None	0
	Weak	1
	Moderate to Strong	2
3. Reasons for living/dying	For living outweigh for dying	0
	About Equal	1
	For dying outweigh the living	2
4. Desire to make active suicide attempt	None	0
	Weak	1
	Moderate to Strong	2
5. Passive suicidal desire	Would take precautions to save life	0
	Would leave life/death to chance	1
	Would avoid steps necessary to save or maintain life	2
6. Duration of suicide ideation/wish	Brief fleeting periods	0
	Longer periods	1
	Continuous (chronic) or almost continuous	2
7. Frequency of suicide ideation	Rare occasional	0
	Intermittent	1
	Persistent or continuous	2
8. Attitude toward ideation/wish	Rejecting	0
	Ambivalent indifferent	1
	Accepting	2
9. Control over suicidal action/acting out wish	Has sense of control	0
	Unsure of control	1
	Has no sense of control	2
10. Deterrents to active attempt	Would not attempt because of a deterrent	0
	Some concern about deterrents	1
	Minimal or no concern about deterrents	2

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Item	Response	Points
11. Reason for contemplated attempt	To manipulate the environment; get attention or revenge	0
	Combination of desire to manipulate and to escape	1
	Escape surcease solve problems	2
12. Method: specificity or planning of contemplated attempt	Not considered	0
	Considered but details not worked out	1
	Details worked out and well formulated	2
13. Method: availability or opportunity for contemplated attempt	Method not available or no opportunity	0
	Method would take time or effort; opportunity not readily available	1
	Method and opportunity available; future opportunity or availability of method anticipated	2
14. Sense of "capability" to carry out attempt	No courage, too weak, afraid, incompetent	0
	Unsure of courage or competence	1
	Sure of competence, courage	2
15. Expectancy/anticipation of actual attempt	No	0
	Uncertain	1
	Yes	2
16. Actual preparation for contemplated attempt	None	0
	Partial	1
	Complete	2
17. Suicide note	None	0
	Started but not completed; only thought about	1
	Completed	2
18. Final acts in anticipation of death	None	0
	Thought about or made some arrangements	1
	Made definite plans or completed arrangements	2
19. Deception or concealment of contemplated suicide	Revealed ideas openly	0
	Total *(Min score 0; Max score 38)*	0

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