



**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: \_\_\_\_\_

Add'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.

## 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:

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

Page | 2

## 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):  
 \_\_\_\_\_

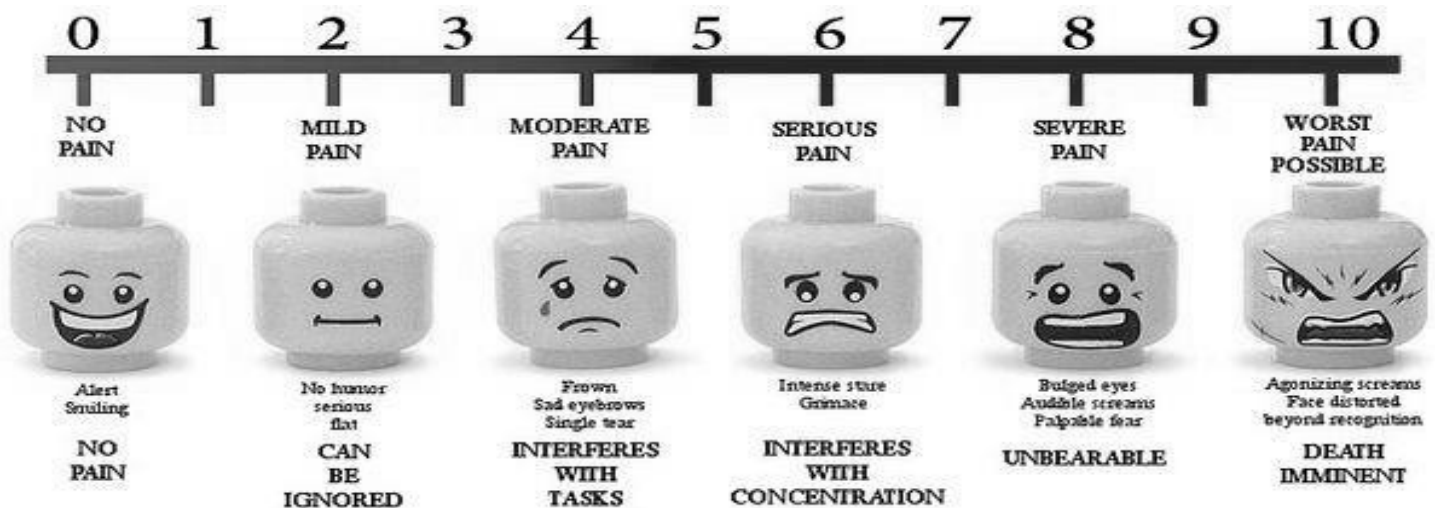
 Are you having any sleeping problems?  
 \_\_\_\_\_

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.



### DRUG & ALCOHOL SCREENING

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

### NUTRITIONAL SCREENING

| #                                 | Description                                                                                                                                                                                                                                                                                                                                                                                                                             | Circle                |                       |
|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
|                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                         | No                    | 2                     |
| 1                                 | Is there an underlying illness with risk for malnutrition or expected major surgery?                                                                                                                                                                                                                                                                                                                                                    | <input type="radio"/> | <input type="radio"/> |
| 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?                                                                                                                                                                                                                                                                              | <input type="radio"/> | <input type="radio"/> |
| 3                                 | Is one of the following items present?<br><ul style="list-style-type: none"> <li>• Excessive diarrhea (<math>\geq 5</math> per day) and/or vomiting (<math>&gt; 3</math> times/day) during the last 1-3 days</li> <li>• Reduced food intake during the last 1-3 days</li> <li>• Pre-existing nutritional intervention (e.g. ONS or tube feeding)</li> <li>• Inability to consume adequate nutritional intake because of pain</li> </ul> | <input type="radio"/> | <input type="radio"/> |
| 4                                 | Is there weight loss or significant increase during the last few week-months?                                                                                                                                                                                                                                                                                                                                                           | <input type="radio"/> | <input type="radio"/> |
| <b>Total (Max score 5 points)</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                       |                       |

#### 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.

### 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I have been treated in the past.                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I am currently in treatment.                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I need mental health help.                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have trouble paying attention?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you often:                                               |                          |                          |
| Feel distrustful of others                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Strange thoughts                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Hear Voices                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Have to do things the same way or keep repeating them          | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have problems in school with:                        |                          |                          |
| Behavior                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Grades                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Skipping Classes                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you worry about your:                                    |                          |                          |
| Eating                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have trouble making or keeping friends?              | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you often feel :                                        |                          |                          |
| Sad                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Angry                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous or Afraid                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you thought about or done any of the following:       |                          |                          |
| Destroy property                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Hurt animals                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Set fire                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Listen to music with violent message                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoke Cigarettes                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Sex without protection                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Suicide attempt                                                | <input type="checkbox"/> | <input type="checkbox"/> |

### 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      |

| 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             |                                                                                            | 0      |
|                                                                  | Revealed ideas openly                                                                      |        |
| <b>Total (Min score 0; Max score 38)</b>                         |                                                                                            |        |