Concurrent Review – PRTF

***Treatment plans/progress notes can be included as needed, but not sent in replacement of completing this form.**

PRTF Name:	Date:
Member Name:	DOB:
Member's Preferred Name:	Member's Pronouns:
UR Contact:	UR Phone #:
UR Email Address:	Fax #:
Attending Physician:	

CURRENT DIAGNOSIS:

CURRENT MEDS/CHANGES:

List current medications:
Frequency of PRNs given in the last 2 weeks. Oral or IM
Medication changes in the last 2 weeks:
Compliance with meds/treatment:

SAFETY CONCERNS (*ONLY* from the last 2 weeks):

Describe any aggressive or assaultive behavior:

Describe any threatening or intimidating behavior causing fear in others:
Describe any poor boundaries that caused anger in others or that required staff intervention:
Describe how often staff support is needed to help member regulate:
Describe the type of support needed to help youth self-regulate, verbal support, one-on-one support, encouragement to become involved with the group, skills or activities used talking, taking a walk, physical activities what coping skills were used:
Describe member's attempts to elope:
Describe member's attempts to self-harm:
Describe any contraband found in member's possession:

Describe when staff intervention was needed to maintain safety (i.e., climbing on furniture, damaging property, etc.):
Describe member's difficulties with ADLs (i.e., not eating, eating nonfood items, not keeping themselves clean, etc.):
Describe when member refuses any therapy session, homework given by therapist, or items on their safety plan:
Describe any time member or family refuses to interact with guardian/case worker/ family through visits, phone calls, or passes:
Describe how often member does not follow established rules or does not follow staff directions:
Describe any suicidal or homicidal ideation:
Describe any hallucinations, delusions, responding to internal stimuli:
Antecedence to undesired events, What is the youth responding to?

SERVICES – Describe frequency and progress in the following services:

Individual Therapy:
Family Therapy (if no family therapy, explain why):
Group Therapy / Psychoeducation Groups:
Medication Management:
School:
Barriers to engage in services:
Other:

PROGRESS MADE:

Interactions with staff and peers:
Progress towards goals:

VISITS – Describe frequency and feedback expressed by both parent and youth related to interactions. List any reports positive interactions, concerns, barriers and or fears reported by all involved. Should also include the length of the pass or visit was it on or off campus, overnight and was the event terminated early for any reason.

Phone calls:
Visits:
Passes:

D/C PLAN:

Foster care agency if applicable:
D/C placement for this individual member:
If D/C placement is unknown, describe what steps have been taken to locate a discharge placement:
Barriers to successful D/C (i.e. difficulties with placement, difficulties setting up services, etc.):
Factors that will delay discharge:
Approximate date of discharge:
Any other pertinent information to know about this member (for example, custody changes, therapist changes, etc.):
D/C Planner Name
D/C Planner Telephone Number: