Facility/Provider Name_____ Member Name or ID# _____

Connecticut BHP
Supporting Health and Recovery

CT BHP MONTHLY TREATMENT PLAN PROGRESS REPORT (MTPPR) – WEB REGISTRATION

ALL FIELDS WITH AN * ARE REQUIRED

*** PLEASE CHECK APPROPRIATE USE:** ☐ **Reassessment (Always)**

***Provider EDS/CMAP ID # (Medicaid 9-digit ID)** _____

***Name of clinician who filled out this form** _____**Credentials/Title** _____

***Contact number** _____ **Ext:**_____

***Facility/Provider Name** _____ Telephone#_____

***Facility/Provider Service Location** _____

***Member Name** _____

***Medicaid/Consumer ID#** _____*DOB: _____ **AND/OR* SSN: _____

*** Requested Start Date (EX: 01/01/2015):** _____**(Should be the due date on the MTPPR tool)**

*** Admit Date (EX: 01/01/2015):** _____**(Date of admission)**

***LEVEL OF SERVICE:** ☐ **INPATIENT/HLOC (ALWAYS)**

***TYPE OF SERVICE:** ☐ **Mental Health** ☐ **Substance Abuse**

***LEVEL OF CARE:** ☐ **Group Home** ☐ **Residential**

***TYPE OF CARE:** ☐ **Group Home (Adult)** ☐ **Group Home 1.0** ☐ **Group Home 1.5** ☐ **Group Home 2.0** ☐ **RTC-Other**

1. *** Has the member already been admitted to the facility?** ☐ Yes ☐ No

LEVEL OF CARE QUESTIONS: *(* signifies a required field)*

2. *** Calling Provider/Facility:** _____
3. **If member's LMHA involved, select LMHA:** ☐ **BIRMINGHAM GROUP HEALTH SERVICES** ☐ **BRIDGES A COMMUNITY SUPPORT SYSTEM, INC** ☐ **CAPITOL REGION MENTAL HEALTH CENTER** ☐ **COMMUNITY HEALTH RESOURCES** ☐ **COMMUNITY HEALTH AFFILIATES, INC** ☐ **CONNECTICUT MENTAL HEALTH CENTER** ☐ **F.S. DUBOIS CENTER (STATE OPERATED)** ☐ **GENESIS CENTER, INC** ☐ **GREATER BRIDGEPORT COMMUNITY MENTAL HEALTH CENTER** ☐ **HARBOR HEALTH SERVICES** ☐ **INTERCOMMUNITY MENTAL HEALTH GROUP** ☐ **NORTH CENTER COUNSELING SERVICES** ☐ **RIVER VALLEY SERVICES** ☐ **RIVER VALLEY SERVICES-OLD SAYBROOK** ☐ **RUSHFORD CENTER** ☐ **SOUTHEASTERN MENTAL HEALTH AUTHORITY** ☐ **SOUTHWEST CT MENTAL HEALTH SYSTEM** ☐ **UNITED SERVICES** ☐ **WESTERN CT MENTAL HEALTH NETWORK** ☐ **WESTERN CT MENTAL HEALTH NETWORK- DANBURY** ☐ **WESTERN CT MENTAL HEALTH NETWORK- TORRINGTON** ☐ **WESTERN CT MENTAL HEALTH NETWORK-WATERBURY**

4. ***Aftercare Follow-Up contact information for member – Please provide at least on method for contacting member for follow-up. If not available, please clarify reason. Phone #:** _____
5. ☐ **Not Available, *Reason:** _____
6. **Members Email Address if available:** _____

7. ***** **Admitting Physician:** _____
8. ***** **Admitting Physician Phone:** _____
9. ***** **Attending Physician:** _____
10. ***** **Attending Physician Phone:** _____
11. ***** **Preparer:** _____(your name here)
12. ***** **Preparer Phone:** _____(your phone here)
13. ***Utilization Review Contact:** _____
14. ***Utilization Review Contact Phone:** _____
15. ***Utilization Review Contact Fax:** _____
16. ***Name of Place/Facility/Institution who referred member:** _____
17. ***If Child, DCF Legal status:** ☐ **Committed** ☐ **CPS IN-HOME** ☐ **Delinquency Pending** ☐ **Dual Committed** ☐ **FWSN** ☐ **FWSN Pending** ☐ **Juvenile Justice** ☐ **N/A** ☐ **Non Committed** ☐ **Open Investigation** ☐ **Order of Temporary Custody** ☐ **Pending 136** ☐ **Probate** ☐ **Protective Supervision** ☐ **Termination of Parental Rights** ☐ **Unknown** ☐ **Voluntary (Age of Majority)** ☐ **Voluntary Services** ☐ **Voluntary Services Pending**

RTC/GH INFORMATION: (** signifies a required field)*

18. ***** **Gender:** _____
19. ***** **Gender Comment:** _____
    _____
20. ***Link Person #:** _____
21. ***Area Office:** _____
22. ***AO BHPD/Parole Officer Name:** _____
23. ***AO BHPD/Parole Officer Phone:** _____
24. ***AO BHPD/Parole Officer Fax:** _____
25. ***DDS CAMRIS ID:** _____
26. ***Date of RTC/GH Admission: (EX: 01/01/2015):** _____
27. ***Child's Guardian:** _____
28. ***Child's Attorney:** _____
29. ***Facility Program:** _____
30. ***Facility Unit:** _____
31. ***Facility Clinician:** _____
32. ***Facility Phone:** _____
33. ***Clinician Phone:** _____

Diagnosis:

34. Behavioral Diagnosis (Primary is required)

*__Diagnosis Code:__ _____ *__Description:__ _____

*__Diagnostic Category:__ _____

Diagnosis Code: _____ Description: _____

Diagnostic Category: _____

35. Medical Diagnosis (Primary is required or indicate "None" or "Unknown")

***Diagnosis Code:** _____ ***Description:** _____

***Diagnostic Category:** _____

36.*Social Elements Impacting Diagnoses (Required - Check all that apply)

□None □Educational problems □Financial problems □Housing problems (Not Homelessness)
□Occupational problems □Other psychosocial and environmental problems_____
□Problems with access to health care services □Homelessness
□Problems related to interaction with legal system / crime □Problems with primary support group
□Problems related to social environment □Medical disabilities that impact diagnosis □ Unknown

37. Functional Assessment (*Optional)*

□CDC- HRQOL □CGAS □FAST □GAF □OMFAQ □SF12 □SF36 □WHO DAS
□OTHER _____ ASSESSMENT SCORE _____

Medical Implications:

38. *Are there any comorbid medical conditions that impact the treatment of the diagnosed MHSU conditions?

□Yes □No □Unknown

39. *Is the individual receiving appropriate medical care for the comorbid medical conditions?

□Yes □No □Unknown

Metabolic Assessment Tool: *(optional)*

40. Current Weight: _____ Height: _____ Waist Circumference: _____

If BMI is not assessed, please indicate reason for not obtaining:

_____
_____
_____

Symptomatology:

41. *Explain the reason for current admission describing symptoms and precipitant (stressor leading to decompensation). For concurrent reviews, list any progress that has been made and remaining symptoms.

CTBHP will always put in this section "See CANS dated 99/99/9999 for clinical information justifying level of care"

_____
_____
_____
_____
_____
_____

Current Risks:

Key: 0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

42. *Members Risk to Self: □0 □1 □2 □3 □N/A

43. ***Members Risk to Others:** □0 □1 □2 □3 □N/A

44. *Substance Use: □0 □1 □2 □3 □N/A

45. ***Legal:** □0 □1 □2 □3 □N/A

Urine Drug Screen (UDS) Completed: □Yes □No □Unknown **Date UDS Completed:** _____

Outcome of UDS: □Positive □Negative □Pending **COWS:** _____ **CIWA:** _____

UDS Positive for (Check all that apply): □Cannabis □Opiates □Cocaine □Amphetamines □Tricyclic Antidepressants □Phenylpropanolamine □Benzodiazepines □Barbiturates □Methamphetamine □PCP □LSD □Methadone □ Other

46. *Blood Alcohol: _____ **□N/A**

Primary Issues/Symptoms Addressed in Treatment: (will be triggered by Dx)

***Indicate primary complex(es) pertinent to this request. You must complete a system complex for the primary behavioral/substance use diagnosis and the primary medical diagnosis (if one was indicated in the Diagnosis section above). Also, if you selected a 2 or 3 for any of the current risks above, you must complete the symptom complex for it below.**

□Danger to Self □Danger to Others □Psychosis □Child/Adolescent Behavior □Eating Disorder
□Neurocognitive □Substance Use □Mood Disorder

47. *Complex #1 Name (from list above): _____

***Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:**

_____
_____
_____
_____

_____

If you selected a 2 or 3 for any of the current risks above, you must complete the symptom complex for it below.

48. Complex #2 Name (from list above): _____

Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:

_____
_____
_____
_____
_____

49. Complex #3 Name (from list above): _____

Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:

_____
_____
_____
_____

50. Complex #4 Name (from list above): _____

Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:

_____
_____
_____
_____

51. ASAM Dimensions (Required if request is Substance Use related):

1. Intoxicated/WD Potential □Low □Medium □High 2. Biomedical Conditions □Low □Medium □High
3. Emotional/Behavioral Conditions □Low □Medium □High 4. Readiness to Change □Low □Medium □High
5. Relapse Potential □Low □Medium □High 6. Recovery Environment □Low □Medium □High

Recovery and Resiliency:

52. *Describe the recovery and resiliency environment to support this individual's long term recovery plan including their personal strengths and support systems available to the member. Include any needs or supports that must be put in place to assist the member's recovery. Please enter goals and progress into this section

_____
_____
_____
_____
_____
_____

_____
_____

53. Current Psychotropic Medications: *(optional)*

Medication 1 Name: _____

Start Date: _____ Date Discontinued: _____ Date Added: _____

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: _____

_____

Medication 2 Name: _____

Start Date: _____ Date Discontinued: _____ Date Added: _____For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: _____

Facility/Provider Name_____ **Member Name or ID#** _____
Medication 3 Name: _____

Start Date: _____ Date Discontinued: _____ Date Added: _____

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: _____

_____

With respect to all medications above, please enter any additional details that would assist in coordinating care:

_____
_____
_____
_____

Medication changes this month: □Yes □No Medication requires serum blood levels: □Yes □No

Date of Most Recent blood draw: _____ □Unknown

Best Practices Endorsement:

54. *I endorse that I follow best practice guidelines for the primary behavioral diagnosis: □Yes □No

If you answered no to the question above, please explain why you will not follow best practice guidelines:

_____
_____

55. *Care Planning Team Includes: □AO/Parole Staff □DCF □DDS Case Manager □Family/Guardian □Member □Milieu Staff □Medical ASO □Outpatient Provider □Peer/FPS □Psychiatrist/Nurse □School □LMHA (if managed by)

56. *Is there a child or adult in member's household in need of any support or service: □Yes □No

***If Yes, select primary support/services needed:** □Behavioral Health Related □Medical Related □Social Services Related □TransportationRelated □Housing Related

***If Yes, select additional support/services needed:** □Behavioral Health Related □Medical Related □Social Services Related □TransportationRelated □Housing Related

***If Yes, describe the support/service that is recommended:**

_____
_____

57. *Is service requested for HLOC because appropriate LLOC is not available: □Yes □No

***If Yes, what LLOC was needed and not available for the member:** □Crisis Stabilization □Obs. Bed □IICAPS □MST □MDFT □FFT □FST □Therapeutic Mentoring □PHP □IOP □EDT □Home Visit □Home Health □Psych Testing □Meth. Maintenance □EPSDT □Outpatient □RTC □Group Home

***If Yes, what is the reason why appropriate LLOC is not available:** □Does not exist in geographic area □At capacity/no openings □Does not provide specialty needed □Member Declined □Hours not Available □Determine Not Crisis □Family Decline □Other _____

Discharge Information:

58. *Planned discharge Level of Care: □Community Support Team □Outpatient □Targeted Case Management □Inpatient □23 Hour □CSU □Partial Hospitalization □Residential Treatment Center □Group Home □Halfway House □Day Services □IOP/SOP □Alternative □Community Support □Day Treatment □Foster Care □In-Home Family Services □Placement Services □PRTF □ Residential Child Care □ Respite □ Specialty Children's Programs□Subacute □Other □Assertive Community Treatment □Facility Based Crisis □Intensive In-Home □MST □NCMC only Ambulatory Detox □ NCMC only Medically Supervised ADATC □ NCMC non Hospital Med Detox □ NCMC only SA Med Monitored Resi □ NCMC only SA non Med Resi over 21 □ Opioid Treatment □Psychosocial Rehab □ Sacot □ Crisis Residential

59. *Planned Discharge Residence: □AWOL □Correctional Facility □Foster Home □Group Home (non therapeutic) □Group Home Pass□Group Home (therapeutic) □Home □Independent Living □Juvenile Detention □Nursing Home/SNF/Assisted Living □PRTF Community □PRTF Solnit □RTC □State Hospital □Supervised/Supportive Housing □Therapeutic Foster Care □Transfer to Alt. Psych or Rehab Facility □Transfer to Medical □Unknown

60. *Expected Discharge Date: *(only required on concurrent reviews)* _____

61. *Preliminary Discharge Plan

_____

_____

_____

62. *Preliminary Efforts taken to affect discharge:

_____

_____

_____

63. *Preliminary Significant Barriers identified for achieving any of the discharge goals:

_____

_____

_____

64. *Current Recommended discharge plan:

_____

_____

_____

65. *Current efforts taken to affect discharge:

_____

_____

_____

66. *Current Significant Barriers identified for achieving any of the discharge goals:

_____

_____

_____

67. *Projected Discharge Date: _____**Name/Relationship with whom child will be placed**_____

68. *Select all who have discussed and are in agreement with discharge plan(check all that apply) : □ Family/Guardian □DCF RRT Liaison □ CTBHP □DCF Area Office/Parole Office □Post Discharge Provider □DMHAS □ DDS Regional Case Manager □Other _____

69. *Will new congregate treatment setting be required post discharge? □Yes □No (**if No, then proceed to Question 79 Additional MTPPR Information)** **If Yes, please complete Questions 69-78.**

Family /Peer Specialist Referral made? □Yes □No *If Yes, date of Referral: _____

Date of CANS submission: _____

Facility/Provider Name_____ **Member Name or ID#** _____

LOC Determined □RTC □ GH 1.5 (PASS) □ GH 2.0 (Therapeutic GH) □Other

DDS Referral Indicated? □Yes □No *If Yes, date of Referral: _____

DMHAS Referral Indicated? □Yes □No *If Yes, date of Referral: _____

Child Specific Conference Needed/Held? □Yes □No *If Yes, date of conference: _____

Purpose of Conference:

_____

_____

Case Specific Conference Needed/Held? □Yes □No *If Yes, date of conference: _____

Purpose of Conference:

_____

_____

Educational placement (PRT) review needed? □Yes □No *If Yes, date of/for PRT: _____

70. *PPT Needed? □Yes □No *If Yes, date of/for PPT: _____

Additional Comments:

_____

_____

_____

71. *Has Member Been Discharged? □Yes □No *If Yes, date of/for PPT: _____

Child/Family Case Worker Needs Describe Needs/Why By Whom/By When:

_____

_____

_____

72. *Name of RTC Therapist Individual Completing MTPPR:

_____

73. *Title/Position:

_____

74. *DCF Worker Name:

_____

75. *DDS Case Manager Name (if applicable)

_____

76. *CTBHP Reviewer:_____

77. *CTBHP Reviewer Phone:_____

78. *Date Completed: _____

ADDITIONAL MTPPR INFORMATION

79. ***DATE MONTHLY REPORTING PERIOD STARTS:** _____**(Prepopulated-if not please call CTBHP)**

80. *DATE MONTHLY REPORTING PERIOD ENDS: _____**(Prepopulated-if not please call CTBHP)**

81. *MTPPR REQUIRED BY: _____**(Prepopulated-if not please call CTBHP)**

82. *CT BHP CARE MANAGER _____ **PHONE:**_____

THERAPY & HOME PASSES

83. *NUMBER OF INDIVIDUAL TREATMENT SESSIONS FOR THIS REPORTING PERIOD (0-30, do not use or "No family resource per DCF"): _____

84. *NUMBER OF INDIVIDUAL TREATMENT HOURS FOR THIS REPORTING PERIOD (0-30) : _____

85. *FOCUS OF INDIVIDUAL THERAPY:

_____

_____

_____

_____

_____

_____

86. *NUMBER OF GROUP TREATMENT SESSIONS FOR THIS REPORTING PERIOD (0-30, do not use or "No family resource per DCF") : _____

87. *NUMBER OF GROUP TREATMENT HOURS FOR THIS REPORTING PERIOD (0-30) : _____

88. *FOCUS OF GROUP THERAPY:

_____

_____

_____

_____

_____

89. *Is Child's primary language English? : ☐ Yes ☐ No If No, did Child receive services in Primary language? ☐ Yes ☐ No

90. *Is Family's primary language English? :☐ Yes ☐ No If No, did Family receive services in Primary language? ☐ Yes ☐ No

91. *NUMBER OF RECREATIONAL TREATMENT SESSIONS FOR THIS REPORTING PERIOD (0-30, do not use or "No family resource per DCF") : _____

92. *NUMBER OF RECREATIONAL TREATMENT HOURS FOR THIS REPORTING PERIOD (0-30) : _____

93. *FOCUS OF RECREATIONAL THERAPY:

_____

_____

_____

_____

_____

_____

FAMILY THERAPY

94. *NUMBER OF SCHEDULED FAMILY TREATMENT SESSIONS FOR THIS REPORTING PERIOD (SCHEDULED BY FACILITY AS PER TREATMENT PLAN) (0-30 or no family resource per DCF) : _____

95. *NUMBER OF SCHEDULED FAMILY TREATMENT HOURS FOR THIS REPORTING PERIOD (0-30 or no family resource per DCF) :

_____

96. *FOCUS OF FAMILY TREATMENT:

97. *RESULTS/PROGRESS/BARRIERS:

98. *NAMES OF PARTICIPANTS IN FAMILY TREATMENT:

99.*NUMBER OF FAMILY VISITS SCHEDULED DURING THIS REPORTING PERIOD (0-30 or no family resource per DCF) :

_____

100. *DETAIL OF FAMILY VISITS:

101.*NUMBER OF FAMILY VISITS ATTENDED DURING THIS REPORTING PERIOD (0-30 or no family resource per DCF) :

_____

102.*FAMILY TREATMENT RESULTS/PROGRESS/BARRIERS:

Facility/Provider Name_____ Member Name or ID# _____

FAMILY READINESS

103. *How prepared to parent does the family/family resource feel? ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

104.*How well has family/family resource developed new/improved skills? ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

FAMILY/FAMILY RESOURCE (FFR) INTERACTIONS

105.*Your rating of FFR interactions with child/youth: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

106.*FFR ratings of interactions with child/youth: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

107.*Child/youth rating of Interactions with FFR: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

HOME PASSES

108.*NUMBER OF HOME PASSES DURING THIS REPORTING PERIOD (0-30 or no family resource per DCF) : _____

109. *IF (1-30) HOME PASSES (DATES TO/FROM) _____ *IF (1-30) HOME PASSES (TOTAL HOURS)_____

110. *INFORMATION RE: HOME PASS:

_____

_____

_____

_____

111.*ADDITIONAL HOME PASS INFO:

_____

_____

_____

_____

_____

_____

112. *OTHER THERAPEUTIC INTERVENTIONS/FOCUS:

_____

_____

_____

RELATIONAL PROGRESS

113.*Interactions with peers: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

114.*Interact ions with Adults/Authorities: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

115.*Willingness for Change: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

116.*Personal Hygiene: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

117.*Respects rights/property of others: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

ACADEMIC ACHIEVEMENT

118.*Interactions with Teachers: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

119.*Interactions with class peers: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

120.*If Regular Ed student, progress in achieve grade level: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

121.*If Regular Special Ed student, progress in achieve IEP goals: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

122.*Days Absent (0-30 or N/A) : _____

123.*Completes assignments: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

124.*School Suspensions (0-30 or N/A): _____

SKILLS OF INDEPENDENT LIVING

125.*Self Care: ☐ Very Good ☐ Good ☐ Fair ☐ Poor

126.*Work Life: ☐ Very Good ☐ Good ☐ Fair ☐ Poor

127.*Daily Living: ☐ Very Good ☐ Good ☐ Fair ☐ Poor

128.*Career Planning: ☐ Very Good ☐ Good ☐ Fair ☐ Poor

129.*Housing & Home Management: ☐ Very Good ☐ Good ☐ Fair ☐ Poor

130.*Social Relationships: ☐ Very Good ☐ Good ☐ Fair ☐ Poor

131.*Home Life: ☐ Very Good ☐ Good ☐ Fair ☐ Poor

132.*Communication: ☐ Very Good ☐ Good ☐ Fair ☐ Poor

133.*Work and Study: ☐ Very Good ☐ Good ☐ Fair ☐ Poor

134.*Overall Assessment: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ N/A

135.*Employment/Summer Jobs on Campus:

_____

_____

INCIDENTS FOR THIS REPORTING PERIOD

136.*NUMBER OF AWOLS DURING THIS REPORTING PERIOD (0-10) : _____

137.*DATES OF AWOLS_____

138. *AWOL INFORMATION:

_____

_____

_____

_____

139.*NUMBER OF POLICE INTERVENTIONS DURING THIS REPORTING PERIOD (0-10) : _____

140.*DATES OF INTERVENTIONS_____

141. *INFORMATION:

_____

_____

_____

_____

142.*NUMBER OF ARRESTS DURING THIS REPORTING PERIOD (0-10) : _____

143.*DATES OF ARRESTS:_____

144. *ARREST INFORMATION:

_____

_____

_____

145.*NUMBER OF REQUESTS FOR 1:1 STAFFING FOR THIS REPORTING PERIOD (0-10) : _____

146.*DATES OF REQUESTS:_____

147. *INFORMATION ON 1:1 REQUESTS:

_____

_____

_____

_____

148.*NUMBER OF RESTRAINTS FOR THIS REPORTING PERIOD (0-10) : _____

149.*DATES OF RESTRAINTS:_____

150. *DECRIPTION OF RESTRAINT DETAIL: _____

_____

_____

_____

151.*NUMBER OF RESTRAINT RELATED INJURIES FOR THIS REPORTING PERIOD (0-10) : _____

152.*DATES OF RESTRAINT RELATED INJURIES:_____

153. *DESCRIPTION OF RESTAINT RELATED INJURIES:

_____

_____

_____

_____

154.*NUMBER OF SECLUSIONS FOR THIS REPORTING PERIOD (0-10) : _____

155.*DATES OF SECLUSIONS:_____

156. *DESCRIBE SECLUSION DETAILS:

_____

_____

_____

_____

157.*NUMBER OF SECLUSION RELATED INJURIES FOR THIS REPORTING PERIOD (0-10) : _____

158.*DATES OF SECLUSION RELATED INJURIES:_____

159. *DETAILS OF SECLUDED RELATED INJURIES:

_____

_____

_____

_____

160.*NUMBER OF MECHANICAL RESTRAINTS FOR THIS REPORTING PERIOD (0-10) : _____

161.*DATES OF MECHANICAL RESTRAINTS:_____

162. *DETAILS OF MECHANICAL RESTRAINTS:

_____

_____

_____

163.*NUMBER OF MECHANICAL RESTRAINT RELATED INJURIES FOR THIS REPORTING PERIOD (0-10) : _____

164.*DATES OF MECHANICAL RESTRAINT RELATED INJURIES:_____

165. *DETAILS OF MECHANICAL RESTRAINT RELATED INJURIES:

_____

_____

_____

_____

166.*NUMBER OF PRN MEDS ADMINISTERED FOR THIS REPORTING PERIOD (0-10) : _____

167.*DATES OF PRN MEDS:_____

168. *ENTER PRN MED INFO/RESPONSE:

_____

_____

_____

_____

169.*NUMBER OF SUICIDAL/SIB ASSESSMENTS (INTERNAL) FOR THIS REPORTING PERIOD (0-10) : _____

170.*DATES OF SIB ASSESSMENT INFO:_____

171. *ENTER SIB ASSESSMENT INFORMATION:_____

_____

_____

_____

172.*NUMBER OF ED VISITS FOR THIS REPORTING PERIOD (0-10) : _____

173.*DATES OF ED VISITS:_____

174. *ENTER ED VISIT INFORMATION:

_____

_____

_____

_____

175.*NUMBER OF INPATIENT ADMISSIONS FOR THIS REPORTING PERIOD (0-10) : _____

176.*DATES OF INPATIENT ADMISSIONS:_____

177. *ENTER INPATIENT ADMISSION INFORMATION:

_____

_____

_____