Application for Residential Treatment Center Placement
(Must completed by physician)

DIRECTIONS: The referring physician must complete this application. In addition, submit any **available** supporting documentation (such as reports listed on the last page) with the application. Residential treatment center (RTC) placement cannot be considered without documentation of treatment, including outpatient intensive measures (multiple weekly visits), family therapy and/or acute inpatient admissions. Health Net Federal Services, LLC (Health Net) will process the request once the physician and family packets have been fully completed and received. Incomplete or illegible documentation will result in a processing delay of this request.

Services must be provided by a KēPRO[SM] certified RTC for children/adolescents. A current listing is available on the KēPRO website: http://tricare.kepro.com.

For questions on the RTC benefit, help locating KēPRO certified facilities or assistance completing this form please contact 1-877-TRICARE (1-877-874-2273). Submit this application and all supporting documentation to 1-877-809-8667.

GENERAL INFORMATION

Date of request:	
Patient Information	
Name:	Patient date of birth:
Address:	
Sponsor name:	Sponsor Social Security number:
Custodial Guardian Information	
Name:	Address:
Home telephone number:	Work telephone number:
Requested RTC Facility Information	
Name:	Telephone number:

CURRENT CONDITION

DIAGNOSIS

AXIS I:
AXIS II:
AXIS III:
AXIS IV:
AXIS V/GAF:

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SYMPTOMATOLOGY CHECKLIST
(As applicable to current condition)

Chronic and persistent danger to self or others
- Fire setting
- Self-mutilation
- Runaway (longer than 24 hours)
- Daredevil/impulsive behavior
  - Specify: _____
- Sexually inappropriate/aggressive/abusive
- Unmanageable behaviors
  - Angry outbursts/aggression
  - Psychotic symptoms
    - Specify: _____
- Present greater than six months: Yes No
- Expected to persist: Yes No

Persistent violation of court orders

Habitual substance use
- Anxiety with associated symptoms increasing
- Depressed/irritable mood and associated symptoms increasing
- Manic/hypomanic and associated symptoms increasing
- Psychotic symptoms increasing

Description of current condition including mental status and behavioral symptoms for which residential treatment might be needed (include explanation of all behaviors checked above):

LIVING SITUATION
Barriers to being managed in the community (including why he/she cannot be managed at home and/or outpatient, etc.):

Community or military agencies involved in working with this patient or with the family (include court/legal history, social services, family advocacy, school system, etc.):

MEDICATIONS (Include all current medications):

Medication	Dosage	Frequency	Start Date

TREATMENT (Start with most recent):

Type of Service (individual, group, family, partial hospitalization, inpatient)	Name of Provider/Facility	Approximate Start/ Admission Date	If outpatient, frequency of services (daily, weekly, etc.)

Patient's response to current treatment program, indicating what aspects have been effective and what aspects have been ineffective:

PHYSICIAN CERTIFICATION

This is to certify I am rendering care to this patient, the above statements are true and appropriate, signed releases for the information provided to Health Net have been obtained. It is my recommendation that this child be admitted to a residential treatment center.

Physician name:	
Physician address:	
Physician phone:	Fax:
Tax ID number:	

(Physician Signature)

(Date)

SUPPORTING DOCUMENTATION

To assist in determining necessity for residential treatment placement, please include the following clinical documentation as available/applicable:

Family/social history
Psychiatric/clinical evaluation (including presenting problem, diagnosis, treatment needs, prognosis)
Current psychological evaluation (including testing)
Educational assessment with levels of academic achievement
Physical and neurological examination results
Discharge summaries from previous inpatient and outpatient treatment