Residential Treatment Center (RTC) form

General information

Date of request: ____________________

Patient information

Name: ____________________ DOB: ____________________

Address: ____________________

City: ____________________ State: ____________________ ZIP Code: ____________________

Sponsor name: ____________________ Sponsor SSN: ____________________

Custodial guardian information

Name: ____________________

Address: ____________________

City: ____________________ State: ____________________ ZIP Code: ____________________

Home phone #: ____________________ Work phone #: ____________________

Requested RTC facility information

Name: ____________________

Phone #: ____________________

Other Health Insurance (OHI): ____________________ Planned target day of admission: ____________________

Referring/Ordering provider

Provider name: ____________________

License type: ____________________ TIN/NPI: ____________________

Phone #: ____________________ Fax #: ____________________

Address: ____________________

City: ____________________ State: ____________________ ZIP Code: ____________________

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Is the requesting provider a military hospital or clinic (MTF)? ☐ Yes ☐ No

Military hospital or clinic name: ______________________________

Facility point of contact: ______________________________

Facility phone #: ____________________ Facility fax #: ____________________

Order Entry Number (OEN)/Genesis number: ____________________ Facility referral ID: ____________________

Facility address: ______________________________

City: ____________________ State: __________ ZIP Code: __________

TRICARE RTC benefit is for anyone under age 21 years, with a behavioral health primary diagnosis. If RTC facility is unknown, type "TBD" and the nearest TRICARE-certified location will be suggested.

Current condition

Current DSM-V diagnosis: ______________________________

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Symptomatology within last six months (as applicable to current condition)

Chronic and persistent danger to self or others:

- ☐ Fire setting
- ☐ Self-mutilation
- ☐ Runaway (longer than 24hrs)
- ☐ Impulsive behavior: (specify) ______________________________
- ☐ Sexually inappropriate/abusive/aggressive
- ☐ 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):

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Provide clinical justification why a lower level of care cannot be used, including history of local higher intensity of care and availability:

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Living situation

Barriers to being managed in the community (including why he/she cannot be managed in the home or at an outpatient setting):

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Discharge plan:

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

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Medications (include all current medications)

Medication	Dosage	Frequency	Start date

Treatment (starting with most recent)

Provider/Facility name	Type of service (individual, group, family, partial hospital, inpatient)	Admission date	Outpatient services Frequency (daily, weekly, etc.)

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

Additionally, the following are deemed true with this submission of referring provider:

- Recommended treatment is necessary, appropriate and not feasible at a lower level of care, or lower level of care efforts have been exhausted.
- Patient is believed to have sufficient ability to participate and respond to therapeutic modalities.
- The parent/guardian will actively participate in family therapy and continuing care of the patient unless therapeutically contraindicated.

Provider signature and credentials: ____ Date: ______________

Note: Referring provider must submit this referral form at **HumanaMilitary.com/referrals** and send to the proposed RTC program.

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