

**I. Referral Information**

Review Type	<input type="checkbox"/> Admission <input type="checkbox"/> Continued Stay <input type="checkbox"/> Psychiatric Intensive Care (PIC) procedure code 90899		
Hospital Facility Name		NPI	
Contact Person		Telephone	
Date of Admission		Court Ordered <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Date

**II. Member Information**

Member Full Name			
Medicaid ID Number		Date of Birth	
Presumptive/Month of Application		Date of Last Authorization	
Living Arrangement	<input type="checkbox"/> Alone <input type="checkbox"/> Shelter <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other		

**III. Diagnosis (List all current diagnoses including complex comorbidities)**


**IV. Current Medications (List all current psychotropic medications)**

Drug Name	Dosage	Frequency

**V. Symptoms and Precipitating Events (Provide details regarding the precipitating events and symptoms/behaviors to support recommendation for inpatient hospitalization)**

**Check all that apply and provide details:**

- |  |  |   |                                    |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Auditory hallucinations | <input type="checkbox"/> Paranoia        | <input type="checkbox"/> Mood/affect        | <input type="checkbox"/> Speech    |
| <input type="checkbox"/> Visual hallucinations   | <input type="checkbox"/> Thought content | <input type="checkbox"/> Dementia/cognition | <input type="checkbox"/> Delusions |
| <input type="checkbox"/> Insight/judgment        | <input type="checkbox"/> Anxiety level   | <input type="checkbox"/> Sleep/hygiene      | <input type="checkbox"/> Behavior  |

Details:

**Imminent risk to self (Check all that apply and provide details):**

- Current, severe, imminent risk of serious self-harm
- Recent suicide attempt or serious self-harm
- Current plan for suicide or serious self-harm
- Command auditory hallucinations for suicide or serious self-harm

Details:

**Imminent harm to others (Check all that apply and provide details):**

- Current, severe, imminent risk of serious harm to others
- Recent action
- Current plan
- Command auditory hallucinations for homicide or serious harm to others

Details:

**VI. Substance Abuse History**

**Provide toxicology screen results (Check all that apply):**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Alcohol - BAL | <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Cannabis      | <input type="checkbox"/> Inhalants       | <input type="checkbox"/> Narcotics    |
| <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Amphetamines    | <input type="checkbox"/> OTC Meds     |

Details:

**CD Consult Recommendation:**

**VII. Discharge Plan**

**Discharge Plan:**

## VIII. Psychiatric Intensive Care (PIC)

**Check all that apply and provide details:**

### Part 1:

- Member must be between 18 and 64 years of age (78.3(8); **and**
- Has a serious mental illness as defined in 44I—subrule 77.47(1); **and**
- Has a current, severe, imminent risk of serious harm to self or others; **and**

### Part 2:

Displays additional complexity of need related to **one** of the following:

- Complex comorbidities, including intellectual or developmental disability, autism spectrum disorder, substance use disorders, or traumatic brain injuries; **or**
- History of violence (clinical risk) or current aggression that is secondary to mental illness; **or**
- A request for member transfer that has been rejected by inpatient level of care by one or more hospitals due to severity of symptoms; **or**
- Lack of responsiveness to typical interventions or a condition that is treatment refractory, **or**
- Disorganized psychotic state or manic thought process that impairs the ability to function, or the safety of the patient or others; **or**
- Behavior that causes significant disruption to the general milieu of the unit (i.e., instigating other patients in negative ways); **or**
- High elopement risk; **or**
- Any other atypical reason that the treating mental health provider feels that additional resources are needed to keep the member and others around the patient safe; **and**

### Part 3:

The member must have a documented need for acute intensive psychiatric care requiring increased or specialized staffing, equipment, or facilities, based on **two or more** of the following:

- Fall precaution protocol in place; **or**
- Restraints or seclusion room requirements; **or**
- Requiring assistance with activities of daily living; **or**
- Requirements for complex nursing care; **or**
- Acutely impaired cognitive functioning from baseline; **or**
- Documentation of interventions to address acute complex mental illness and comorbidities; **or**
- Safety protocols in place to address the physical risk posed to staff, other patients, and infrastructure; **or**
- Elopement risk precaution protocol in place.

Provide details and attach documentation to support any of the selected criteria.

Details:

**PIC Discharge Plan (if discharge plan was completed above, leave this blank)**

**Discharge Plan:**

**IX. Attestation**

**I confirm all information is a true and accurate description of the above individual.**

Completed by  
(Print Name\*)

Email

Date

*\*By typing my name, I am electronically signing this document in accordance with Iowa Code Chapter 554D.*

Upon completion of the form, please save the document to your computer, then click the “**SUBMIT**” button below which opens an email with the completed document attached. Click **Send** and the document will be sent to the Iowa Medicaid Medical Services Unit.

**SUBMIT**