RECERTIFICATION OF NEED (RON)
(Level 1 Facilities)
Fax to: (602) 253-6695

For ADHS/DBHS use only: _____Approved _____ Not approved Date: _____ Reviewed by:_____

☐ Inpatient Psychiatric Services ☐ C/A Residential Treatment Center

Date Due:_____
Date and Time RON completed: _____ Date of Admission: _____

Client Name: _____ AHCCCS ID #: _____ D.O.B.:_____
Case Manager: _____ RBHA: _____

Diagnosis *(**Must be numeric value per ICD 10 criteria**)*: _____

Reason for Continued Stay: *Check at least **ONE** from both **A** and **B, or C** and check **ALL** that apply from the Continued Stay Criteria below:*

A. **Severity of Illness:** *(explain below)*

- ☐ Persistence of disabling symptoms;
- ☐ Serious adverse reaction or non-response to medication, procedures, or therapy;
- ☐ Failure to attain treatment goals resulting in continuation of severe impairment of the client's physical, social, or behavioral functioning;
- ☐ Degree of illness precludes outpatient management; and
- ☐ Level I treatment course demonstrating lack of discharge readiness; e.g., Absent Without Leave (AWOL), suicide attempt, Dangerous To Others (DTO), Dangerous To Self (DTS)

B. **Intensity of Service** *(explain below)*

- ☐ Continues to need 24-hour/day close and continuous supervision of psychiatric condition;
- ☐ Significant impairment continues in familial, social, or academic environment;
- ☐ Pharmacotherapy with close observation and/or laboratory monitoring, and/or nursing supervision;
- ☐ Frequent redirection and/or observations which may include the use of time-outs, seclusion and restraint;
- ☐ The presence of a medical condition significantly hindering the treatment of the psychiatric condition.

Present Symptoms and Specific Behavior that support each reason for continues from A & B.

C. **Less restrictive resources available in the community still do not meet the treatment needs of the client.** **Yes** ☐ **No** ☐

Specify the alternatives considered, and issues that indicate need for continued stay.

D. **Discharge Plan: Inpatient services can reasonably be expected to improve the client's condition or prevent further regressions.** Yes ☐ No ☐

Estimated L.O.S. _____

Current Medications:_____ Dose: _____ Frequency: _____ Date Started:_____

Medication changes in the past 30 days and reasons for the change: ____
Client ID# _____ Client Name: _____

Describe the clinical plan to resolve the remaining treatment needs (i.e., describe the changes to the treatment plan that will foster the attainment of the treatment goals):

Mental Status:

Oriented: _____ *(Time, Person, Place, Situation)* **Level of alertness** ☐ Full ☐ Partial

Speech ☐ Normal ☐ Abnormal: *Specify* _____ **Sleeping** ☐ Normal ☐ Abnormal: *Specify* _____

Eating ☐ Normal ☐ Abnormal: *Specify* _____

Mood ☐ Normal ☐ Depressed ☐ Elevated ☐ Agitated: *Specify* _____

Affect ☐Normal ☐ Constricted ☐ Blunted ☐ Other: *Specify* _____ **Mannerisms** ☐ Normal ☐ Abnormal: *Specify* _____

Behavior ☐ Actively Participates ☐ Refuses activities or treatment ☐ Cooperative ☐ Uncooperative

Delusions ☐ None ☐ Active: *Specify* _____

Hallucinations ☐ None ☐ Auditory ☐ Visual ☐ Olfactory

Thought Process ☐ Normal/Logical ☐ Abnormal: *Specify* _____

Associations ☐ Normal ☐ Abnormal: *Specify* _____ **Stream** ☐ Normal ☐ Abnormal: *Specify* _____

Judgment ☐ Good ☐ Impaired/Limited ☐ Fair ☐ Poor ☐Other_____

Insight ☐ Good ☐ Impaired/Limited ☐ Fair ☐ Poor ☐Other_____

DTS Behaviors: ☐ **Recent**: *specify dates*_____ ☐ Potential/At Risk for ☐ None

DTO Behaviors: ☐ **Recen**t: *specify dates*_____ ☐ Potential/At Risk for ☐ None

Disposition/ Discharge Plan and Barriers to Discharge:

I am aware of the client's condition and have been provided sufficient information to determine this level of care is appropriate.

Signature: _____ **Print Name & credentials**: _____
(Signature by Physician, Physician Assistant or Nurse Practitioner)

Date signed:_ Click here to enter a date.
Revision date: 05/30/14