



IPR – INSTITUTIONS FOR MENTAL DISEASE
 UNDER AGE 21

FORM
 DM-8

Name		County Finance	Physician
Social Security Number	Date of Birth	Date of Admission	Type of Admission
DIAGNOSIS	Primary		
	Secondary		
CERTIFICATION	MC-14 Dated	Completed within 48 hours of admission? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PLAN OF CARE	Date of Plan of Care	Developed and implemented within 14 days after admission? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Date of Last Review	Reviewed every 30 days by the team? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Physician's Orders (Medication and Treatments)

Physician Monthly Medication Review Yes No Annual Physical Examination Date _____

PLAN OF CARE

Identification of Program Elements (List in brief)

SAMPLE

REVIEW OF PLAN	Yes	No
Documentation of active treatment		
Presence of interdisciplinary involvement		
Identification of treatment objectives		
Appropriate?		

Comments

	Yes	No
Does the charting indicate that the planned services are being delivered?		
Does the progress noted indicate reasonable improvement in the patient's condition?		
Is discharge planning present?		
If not, is reason stated?		

Behaviors/Care Needs Precluding Care in a Less Restrictive Environment

Client Visit (Observations/Comments)

REVIEW TEAM FINDINGS		Yes	No
Client observed and visited?			
Current placement in the facility is appropriate?			
Services rendered are adequate and responsive to the needs of the individual?			
Is change to other living arrangements indicated?			

Team Recommendations:

Sign Here	Psychiatric Physician	Registered Nurse	Date Signed
	Social Services Reviewer	Other	