Multi-Disciplinary Team (MDT) Meeting Note

Member's Name: _____ Date of Birth: _____ Medicaid ID#: _____

Gender Identification: _____ FSFN Person ID#: _____ FSFN Case ID#: _____

MDT Meeting Date: _____

Type of MDT: ☐ Initial ☐ Subsequent ☐ Other: _____

Last MDT Date: _____

Anticipated Discharge Date (if applicable): _____ Authorization Expiration Date (if applicable): _____

CURRENT PLACEMENT AND LEVEL OF CARE/TREATMENT							
Type		*Provider/Program/Agency*	*Level of Care/Treatment Services*				
☐	Foster Home		☐	STFC Level I	☐	Outpatient (Individual)	
☐	Therapeutic Home		☐	STFC Level II	☐	Outpatient (Group)	
☐	Group Care		☐	STFC Crisis	☐	TBOS	
☐	Therapeutic Group		☐	STGC/STGH	☐	BHOS	
☐	Residential Facility		☐	SIPP	☐	Other:	
☐	Other:		☐	Residential Treatment (RTC)	☐	n/a	

CASE CONTACT INFORMATION

Dependency Case Manager:	_____	Telephone:	_____
		Email Address:	_____
Caregiver and/or Parent:	_____	Telephone:	_____
		Email Address:	_____
Guardian ad Litem:	_____	Telephone:	_____
		Email Address:	_____
Targeted Case Manager:	_____	Telephone:	_____
		Email Address:	_____
Therapist/Counselor:	_____	Telephone:	_____
		Email Address:	_____
Primary Care Physician:	_____	Telephone:	_____
		Group Name:	_____
Other Involved Party:	_____	Telephone:	_____
		Email Address:	_____

Primary Insurance: _____ Secondary/Other Insurance: _____

Eligible for SSI: ☐ Yes ☐ No APD Involvement: ☐ Yes ☐ No

Permanency Status: ☐ Reunification ☐ Termination of Parental Rights ☐ Permanent Guardianship
☐ Adoption ☐ APPLA ☐ Other: _____

Safety Plan(s): _____

Family Interaction/Visitation Status: _____

School: _____ Grade Level: _____ History of Repeating Grades: ☐ Yes ☐ No

Current Academic Needs: ☐ Special Education ☐ Psychological Testing ☐ Other: _____
☐ IEP ☐ Full Scale IQ

Comment(s):	

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PROVIDER/TREATMENT INFORMATION

Date of *Last* Psychiatric Evaluation: _____ Date of *Last* Psychological Evaluation: _____

Date of *Last* Neuro- Psychological Evaluation: _____ Date of *Last* Evaluation (Other): _____

Date of *Next* Psychiatric Evaluation: _____ Date of *Next* Psychological Evaluation: _____

Date of *Next* Neuro- Psychological Evaluation: _____ Date of *Next* Evaluation (Other): _____

TREATMENT HISTORY (check all that apply)

☐ Outpatient ☐ TBOS ☐ BHOS ☐ STFC Level I

☐ STFC Level II ☐ STGC/STGH ☐ SIPP ☐ Other:

Provider Name: _____ Treatment Dates: _____ - _____

Type of Treatment: _____

Telephone: _____ Email Address: _____

Discharge Information: _____

Provider Name: _____ Treatment Dates: _____ - _____

Type of Treatment: _____

Telephone: _____ Email Address: _____

Discharge Information: _____

Provider Name: _____ Treatment Dates: _____ - _____

Type of Treatment: _____

Telephone: _____ Email Address: _____

Discharge Information: _____

Provider Name: _____ Treatment Dates: _____ - _____

Type of Treatment: _____

Telephone: _____ Email Address: _____

Discharge Information: _____

Comment(s):	

Mental Health Diagnosis/es: _____

Cognitive Functioning/ASD: _____

DJJ Involvement/History: _____

Substance Abuse Issues/History: _____

Inpatient Hospitalization/Last 12 Months: _____
(Psychiatric-Suicidal /Homicidal Ideation)

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Member's Name: ____________ Date of Birth: ____________ Medicaid ID#: ____________

Current Presentation and Mental Health Status:	

Please indicate any current symptoms: ☐ No Current Symptoms

Symptom	Frequency/Duration	Symptom	Frequency/Duration
☐ Auditory/Visual Hallucinations		☐ Animal Cruelty	
☐ Delusions		☐ Difficulty with Activities of Daily Living	
☐ Eating Disorder		☐ Elopement	
☐ Enuresis/Encopresis		☐ Extreme Impulsivity	
☐ Fire setting		☐ Homicidal Ideation and/or Gestures	
☐ Impaired Self-Concept		☐ Lying	
☐ Nightmares or Sleepwalking		☐ Physical and/or Verbal Aggression	
☐ Property Destruction		☐ Self-Destructive	
☐ Self-Injurious		☐ Sexualized Behaviors/Activities/Deviance	
☐ Stealing		☐ Substance Abuse	
☐ Suicidal Ideation and/or Gestures		☐	

Additional Comments and/or Explanation of Symptoms:	

Strengths: ____________

Challenges: ____________

MEDICAL INFORMATION/MEDICATION HISTORY

Current Medical Conditions and Medication Comments:	

Children's Medical Services (CMS) Involvement? ☐ Yes ☐ No

Date of Most Recent Medication Appointment: ____________ Date of Next Medication Appointment: ____________

Medication: ____________ Currently Taking? ☐ Yes ☐ No

Type: ☐ Medical/Physical Health ☐ Psychotropic First Prescribed: ____________ Last Prescribed: ____________

Reason for Medication: ____________

Dosage: ____________ Frequency: ____________ Prescribing Physician: ____________

Medication: ____________ Currently Taking? ☐ Yes ☐ No

Type: ☐ Medical/Physical Health ☐ Psychotropic First Prescribed: ____________ Last Prescribed: ____________

Reason for Medication: ____________

Dosage: ____________ Frequency: ____________ Prescribing Physician: ____________

Medication: ____________ Currently Taking? ☐ Yes ☐ No

Type: ☐ Medical/Physical Health ☐ Psychotropic First Prescribed: ____________ Last Prescribed: ____________

Reason for Medication: ____________

Dosage: ____________ Frequency: ____________ Prescribing Physician: ____________

Medication: ____________ Currently Taking? ☐ Yes ☐ No

Type: ☐ Medical/Physical Health ☐ Psychotropic First Prescribed: ____________ Last Prescribed: ____________

Reason for Medication: ____________

Dosage: ____________ Frequency: ____________ Prescribing Physician: ____________

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MDT Level of Care Recommendation(s)

☐ STFC Level I ☐ No recommendation for a higher level of care
☐ STFC Level II ☐ Other: _____

Is a Suitability Assessment Needed?	☐ Yes	☐ No	Has one been completed?	☐ Yes	☐ No
☐ Initial	Date: _____	Recommendation:	☐ STGC/STGH	☐ SIPP	☐ Alternative
☐ 90 Day Review	Date: _____	Recommendation:	☐ STGC/STGH	☐ SIPP	☐ Alternative
☐ Reconsideration	Date: _____	Recommendation:	☐ STGC/STGH	☐ SIPP	☐ Alternative

Next Suitability Assessment Due Date: _____

Comment(s):	

DISCHARGE PLANNING ACTIVITIES

ADDITIONAL MDT RECOMMENDATIONS AND FOLLOW-UP ITEMS		
Action Item/Recommendation	*Responsible Party*	*Target Date for Completion*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Next MDT Date: _____

Multi-Disciplinary Team (MDT) Meeting Note

Member's Name: ____________________ Date of Birth: ______________ Medicaid ID#: ______________

MULTI-DISCIPLINARY TEAM COMMITTEE MEMBERS		
MDT Participant Name	*Organization*	*Attendance*
CBC Behavioral Health Coordinator or Designee		☐ Present ☐ Telephone ☐ Not Present
Child Welfare Case Manager or Designee		☐ Present ☐ Telephone ☐ Not Present
Clinician or Health Care Representative		☐ Present ☐ Telephone ☐ Not Present
Enrollee/Member (Child)		☐ Present ☐ Telephone ☐ Not Present
Parent		☐ Present ☐ Telephone ☐ Not Present
Caregiver/Guardian		☐ Present ☐ Telephone ☐ Not Present
Guardian Ad Litem		☐ Present ☐ Telephone ☐ Not Present
CBC Nurse Care Coordinator		☐ Present ☐ Telephone ☐ Not Present
Targeted Case Manager (if applicable)		☐ Present ☐ Telephone ☐ Not Present
Title:		☐ Present ☐ Telephone ☐ Not Present
Title:		☐ Present ☐ Telephone ☐ Not Present
Title:		☐ Present ☐ Telephone ☐ Not Present
Title:		☐ Present ☐ Telephone ☐ Not Present
Title:		☐ Present ☐ Telephone ☐ Not Present
Title:		☐ Present ☐ Telephone ☐ Not Present
Title:		☐ Present ☐ Telephone ☐ Not Present
Title:		☐ Present ☐ Telephone ☐ Not Present
Title:		☐ Present ☐ Telephone ☐ Not Present

Please indicate below if you are <u>not</u> in agreement with the MDT recommendation(s)

Name	*Comments*	*Initials*

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