Arkansas Authorization | Organizational Determination Request Form

Please return this completed form and supporting documentation by fax to:

☐ All FEP/Exchange/Octave: **501-301-1996** | ☑ Standard Requests: **501-301-1994** | ☑ Urgent Requests: 501-301-1986

Or by email to: intaketeam@arkbluecross.com

By checking the Urgent Requests box or faxing to this number you certify that waiting could place the members life, health or ability to regain maximum function in jeopardy.

Contact information (for the person with whom we need to communicate about this request)

Contact name	**Direct phone & Ext**
Perimeter Behavioral	870-394-7100

Email **Preferred fax for determination and correspondence**

Member information

First name	**Middle initial**	**Last name**
Kennedy		Stultz

Member ID number (including prefix)	**Member date of birth** (mm/dd/yyyy)	**Phone**
NCSM6160494300	11/07/2008	(870) 919-3027

Member address	**City**	**State**	**ZIP**
2706 Oxford St.	Paragould	AR	72450

Medical service/Procedure/Course of treatment/Device information

Authorization type (Please Check Only One Box)
If this is related to an existing authorization, please provide the authorization number: _____

☑ Inpatient ☐ Outpatient

☐ Drug, Under Medical benefit (any healthcare professional administered injection and/or infusion, CAR-T, or gene therapy billed under the medical benefit by provider, facility or specialty pharmacy)

Treatment type (Please Check Only One Box)

☐ Medical	☐ Home Health/ Skilled Nursing	☐ Hospice	☐ High-Tech Radiology
☐ Surgical	☐ PT/OT/ST	☐ Delivery	☐ Medical Oncology
☑ Behavioral	☐ DME	☐ Swing Bed	
		☐ CT/PET Scans, MRIs	

Request type (Please Check Only One Box)

☑ Initial ☐ Retrospective ☐ Concurrent ☐ Org Determination/Benefit Inquiry Only (for codes not on PA list)

☐ Exception (Out of Network, Benefit, etc.)

Please note: The turnaround time for most OD&BI request is ten (10) business days.

Place of service (Please Check Only One Box)

☐ School	☐ Emergency Room	☐ Hospice	☐ Outpatient Hospital
☐ Office	☐ Ambulatory Surgery Center	☐ Observation	☐ Neuro Restorative Treatment Facility
☐ Home		☐ Rehabilitation Center	
☑ Inpatient Facility	☐ Skilled Nursing Facility	☐ LTAC	☐ PT/OT/ST

Requestor & Provider details

Requestor: ☐ Member ☐ Authorized Representative ☑ Provider ☑ Facility

Requesting provider

Provider name	**Tax ID #**	**NPI #**	**Specialty**
Dr. Nga Huynh	461030276	1679716013	Psychiatrist

Group/Facility name	**Group/Facility NPI #**	**Phone**
Perimeter Behavioral	1134521685	870-394-7100

Group/Facility address	**City**	**State**	**ZIP**
600 N 7th St.	West Memphis	AR	72301

Servicing provider

Provider name	Tax ID #	NPI #	Specialty
Dr. Nga Huynh	461030276	1679716013	Psychiatrist

Group/Facility name	Group/Facility NPI #	Phone	Preferred Fax
Perimeter Behavioral	1134521685	870-394-7100	870-394-7271

Group/Facility address	City	State	ZIP
600 N 7th St.	West Memphis	AR	72301

Diagnosis and procedure codes (if you have more than three codes for either section, just type the codes separated by commas)

Diagnosis ICD (list primary first)	ICD Description
F31.9	Bipolar disorder, unspecified

HCPCS/CPT/CDT code	Code description	Medical reason	Start date	End date	Dose and frequency requested

Details

For inpatient admissions

☐ Emergent ☑ Elective

Admission date & time	Expected discharge date & time	Days requested
11/03/2025 21:05	11/10/2025	7

Bed type

☐ ICU Adult ☐ ICU Pediatric ☐ NICU ☐ Med Surg Adult ☐ Med Surg Pediatric ☐ Labor & Delivery

For procedures

Start date	End date	Unit type	Units requested
		☐ Units ☐ Days ☐ Hours ☐ Visits	

For medical benefit Rx

Start date	End date	Dose	Frequency

Route

☐ Intramuscular (IM) ☐ Intravenous (IV) ☐ Subcutaneous (SC) ☐ Topical (TOP) ☐ Other _____

Other clinical information

Include/attach clinical and office notes, laboratory information, imaging reports, and any other necessary information to support this request. If this is a request for out-of-network services, please provide an explanation.

Instructions: Please fill out all applicable sections on all pages completely and legibly before faxing the form to the number listed. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support this request. Information contained in this form is Protected Health Information under HIPAA. If this request is for a prescription drug on the pharmacy benefit or for a transplant, please fill out the applicable form.

STULTZ, KENNEDY Patient

Member ID	Date of Birth	Gender
M6190871101	2008-11-07	NA

Transaction Type	Organization	Payer
Inpatient Authorization	WOODRIDGE OF WEST MEMPHIS, LLC	ARKANSAS BCBS

Arkansas

Oops! Availity is experiencing connection problems with the health plan. Try your request again later. If the problem continues, contact Availity Client Services at 1.800.AVAILITY (282.4548).

Certificate Information

Reference Number
)001-1545210

Status
CONTACT PAYER

Service Information

Service Type

Admission - Discharge Date
2025-11-04 - 2025-12-04

Requesting Provider

Name

NPI
1134521685

Provider Role
Facility

Transaction ID: 40498011 Customer ID: 658625 Transaction Date: 2025-11-04

Arkansas

STULTZ, KENNEDY Patient

Member ID	Date of Birth	Gender
M6190871101	2008-11-07	Female

Eligibility Status	Group Number	Plan / Coverage Date
Active Coverage	0309200005	2025-10-01 - 9999-12-31

Transaction Type	Organization	Payer
Inpatient Authorization	WOODRIDGE OF WEST MEMPHIS, LLC	ARKANSAS BCBS

Certificate Information

Reference Number	Status
NA	CANCELLED

Review Reason 1
Duplicate Request

Member Information

Patient Name	Patient Date of Birth	Patient Gender
STULTZ, KENNEDY	2008-11-07	Female

Member ID	Relationship to Subscriber	Subscriber Name
M6190871101	Self	STULTZ, KENNEDY

Requesting Provider

Name
PERIMETER BEHAVIORAL

NPI
1134521685

Specialty
363LA2100X

Provider Role
Facility

Service Information

Service Type
A4 - Psychiatric

Place of Service
21 - Inpatient Hospital

Admission - Discharge Date
2025-11-03 - 2025-11-10

Admission Type
Elective

Quantity
7 Days

Diagnosis Code 1
F319 - Bipolar disorder unspecified

Procedure Code 1 (CPT/HCPCS)
G4013 - Mntal/behav/psych hlth ss

Quantity
7 Days

Procedure From - To Date
2025-11-03 - 2025-11-10

Status
NOT CERTIFIED

Status Reason
Duplicate Request

Rendering Provider/Facility

Provider 1

Name
HUYNH, NGA

NPI
1679716013

Specialty
363LA2100X

Provider Role
Attending

Address
600 N 7TH ST., WEST MEMPHIS, AR 72301

Fax
(870) 394-7271

Provider 2

Name
WOODRIDGE OF WEST MEMPHIS, LLC

NPI
1134521685

Provider Role
Facility

Address
600 N 7TH ST, WEST MEMPHIS, AR 72301

Phone
(615) 860-9230

Fax
(615) 860-9228

Woodridge of West Memphis 001060

MED REC	ACCOUNT	N/S	ROOM	BED	SEX	BIRTHDATE	AGE	SOC SEC #	MARITAL STATUS	LEGAL STATUS
62676	1060006577	UNT1	00199	Y	F	11/07/2008	16Y	679-16-1013	Single	VOL

PATIENT NAME Stultz, Kennedy	**SALUT**	**PREFERRED NAME** Kennedy	
INSURED NAME Key, Heather			
ADDRESS 2706 Oxford St. Paragould, AR 72450			**COUNTY** Greene
PATIENT TYPE Inpatient Psych	**PROGRAM** Adolescent Acute		
GRADE LEVEL 11	**RELIGION** Other	**RACE** White	**PHONE**
ADMISSION DATE 11/03/2025	**TIME** 21:05	**ADMITTED FROM** HOME	
ADDRESS			
PREFFERED LANGUAGE English		**ALLERGIES** Penicillin, Keflex, Sulfa	
EMPLOYER'S NAME		**CODE STATUS**	
EMPLOYER'S ADDRESS			
REFERRAL SOURCE NAME Key, Heather		**REFERRAL ORGANIZATION** HOME	
REFERRAL SOURCE CONTACT 870-919-3027			
PCP NAME		**PRIMARY THERAPIST**	
CONSENTS SIGNED TO RELEASE INFO TO:			

CONTACT NAME RELATION	HOME # WORK # CELL #	ADDRESS	GUAR	EMER	POAF	POAM	LGAR
Heather Key Mother	 870-919-3027	2706 Oxford St. Paragould, AR 72450	Y	Y	N	N	Y

INSURANCE RANK	INSURANCE NAME	AUTHORIZATION #	ID NUMBER
Primary	BCBS Arkansas		XCFM6190871101
Secondary	Self Pay after Insurance		1060006577

MOST CURRENT DSM/ICD DIAGNOSES: PSYCHIATRIC	MOST CURRENT DSM/ICD DIAGNOSES: MEDICAL
F31.9 Bipolar disorder, unspecified	

ADMITTING DIAGNOSIS: PSYCH	PSYCHOSOCIAL	MEDICAL
F31.9 Bipolar disorder, unsp		

PHYSICIANS	NAME	WORK	EMAIL	CELL	HOME
Attending	Huynh, Nga	870-394-7100			

DISCHARGE DIAGNOSIS:	DISCHARGE DATE: TIME:	DISCHARGE TO

PERIMETER
Behavioral Hospital
of West Memphis

Referral Call Form

Date: 11/03/

Received via:

- [x] Call Start Time: 08:53 End Time: 09:07
- [ ] Fax Received Time: _____

Received By (First and Last Name): Jasmine Parker

Caller Data (Hello. This is _____. How may I help you?) (Can I get your Name and Phone number?)

Caller Name: Heather Key **Relationship to Patient:** Mother
Agency: Guardian **City:** Paragould
Caller Phone: 870-919-3027 **Caller Fax:** _____

Patient Information (Can I get some information about the person you are calling about? (If not Caller.)

Patient Name: Kennedy Stultz **DOB:** 11/07/2008 **Age:** 16
Gender: F **Patient Phone:** 870-919-3027 **Race:** W **SSN:** 679-16-1013
Patient Address: 2706 Oxford St. Paragould, AR 72450

Emergency Contact Information

Name: Heather Key **Relationship to Patient:** Mother
Phone: 870-919-3027 **Address:** 2706 Oxford St. Paragould, AR 72450

Referral Data *If Caller not Referral Source (Did your PCP or OP provider refer you to us today?) (How did you hear about us?)

Referring Agency: _____
Point of Contact: _____ **Phone:** _____
Fax: _____ **Address:** _____

Clinical Situation (Tell me about the problem you are experiencing.) (Are you currently safe?)

Presenting Problem: The pt. is presenting w/ SI w/ a plan to cut to herself w/ a razor blade. She has a hx of cutting herself w/ an eye-brow razor and uses her nails to scratch herself.

heatherkey@amcmedicalclinic.com

HIGH RISK FACTORS: *(check all that apply)*

- [x] Suicidal
- [ ] Homicidal
- [ ] Psychotic
- [ ] Self-harm
- [ ] Aggression
- [ ] SAO
- [ ] Substance Use

MEDICAL ISSUES:
None reported

Insurance Information (To expedite the assessment process, we like to ... insurance information before you arrive.)

11/03/2025; 21:05

PRIMARY INSURANCE	
Carrier: BCBS OF AR	**Carrie** Woodridge of West Memphis
Subscriber Name: Heather Key SSN: 486-88-1282 **DOB:** 11/05/1980	**Subsc** Stultz, Kennedy; F; 11/07/2008; 16Y
Policy Number: XCFM6190871101	**Policy** Huynh, Nga; M/R: 62676; ACC: 1060006577

Place Patient Label Here

PERIMETER
Behavioral Hospital
of Springfield

Referral Call Form

Assessment (Offer to Schedule Assessment within 24*)

Asmt Scheduled: Date_____ **Time**_____ **If No Asmt Scheduled, Why:** _____

☐ **Approved Following Initial Clinical Review Received**

Follow up & Notes (Follow up 3 times within 72 hours for no-show appointments)

3. **Follow up: Date:**_____ **Time:**_____ **By:**_____
Notes: _____

2. **Follow up: Date:**_____ **Time:**_____ **By:**_____
Notes: _____

1. **Follow up: Date:**_____ **Time:**_____ **By:**_____
Notes: _____

NOTES: _____

11/03/2025; 21:05

Woodridge of West Memphis
Stultz, Kennedy; F;
11/07/2008; 16Y
Huynh, Nga;
M/R: 62676; ACC: 1060006577

PERIMETER
Behavioral Hospital
of Springfield

Referral Call Form

Disposition *Please Indicate Date if Different from Referral Received Date

Time Notified Physician: _____

☐ **Pending (Reason):** _____

Time Decision from Physician: _____

☒ **Accept**

☐ **Deflect** **Reason:** _____

☐ **Deny** **Reason:** _____

***If Deflected/Denied, Referral Provided To:** _____

Time Staffed with AOC (if applicable): _____

Time Notified Nursing Staff: 10:04

Time Notified Referral Source of Disposition: _____

Time Notified Guardian: 09:09 **Guardian Response:** Accept

Completed By: Jasmine Parker, MA Date/Time: 11/03/2025

For Office Use:

☐ **Call Entered into WellSky Interactant via Referral Management**

By Whom: Jasmine Parker, MA

☐ **Admission Status Updated in WellSky Interactant**

By Whom: _____

☐ **Director Reconciled Referral Call with WellSky Interactant**

Director Initial: _____

Woodridge of West Memphis
Stultz, Kennedy; F;
11/07/2008; 16Y
Huynh, Nga;
M/R: 62676; ACC: 1060006577

PERIMETER Behavioral Hospital

Assessment & Referral Evaluation

Patient Name: Kennedy Stultz Date: 11/03/2025

Start Time: 09:09	Accompanied By: Heather Key	DOB: 11/07/2008	Age: 16

Legal Status: ☑ Voluntary ☐ Involuntary; *(choose one if applicable)* N/A County: Green

Lives With: Mother

Social Supports: Mother & grandparents

What is the patient's Sexual Orientation and/or Gender Identity?

□ Male □ Assigned/Designated Male at Birth

■ Female ■ Assigned/Designated Female at Birth

☐ LGBTQ
☐ LGBTQIA, LGBTQ+, LGBTQIA1
☐ Lesbian, gay or bisexual
☐ MSM (men who have sex with men)
☐ Pansexual ☐ Asexual ☐ Non-binary
☐ Transgender ☐ Two-spirit
☐ Gender diverse ☐ Gender non-conforming
☐ People/person with intersex traits

Does patient have any needs that require special accommodations: ☑ N/A ☐ Cultural ☐ Religious ☐ Diet
☐ Other/Explain:

Patient's primary Language: English Patient's language of choice: ■ English □ Spanish □ Other:

CHIEF COMPLAINT (in patient's own words & in family's own words)

Per Patient: N/A

Per Family: She's having suicidal ideations.

PRECIPITATING EVENTS (events that occurred within the last 72 hours that prompted the assessment)

The patient's mother got a call from the school social worker that she received a report from a student that Kennedy was going to cut and kill herself. The patient told her mother that it was true and when they got home, she gave her mother the razor blade that she was keeping in her bedroom. The patient states she was sexually assaulted the night before and had been feeling suicidal ever since. The patient's mother states the patient has been having manic episode since this past summer. She has compulsive sexual behaviors, she's been stealing, running away from home, a compulsive liar, and will become physically aggressive. The patient is in in need of acute care for stabilization.

BASELINE BEHAVIORS (when patient is stable, how is functioning at school/home/social?)

When stable, her behavior is good; she's usually pretty sweet.

Current Medication List

Allergies: Penicillin, Keflex, Sulfa

Current height: 5'4 Weight: 124

Medication, Dose, Route, Frequency	Indication/Reason	Medication, Dose, Route, Frequency	Indication/Reason
Vyvanse 40mg 1x day	Mood		
Zoloft 100mg 1x day	Mood		
Propranolol 10mg up to 6x day	Anxiety/ hand tremor		
Lo loestrin	Birth control		

☑ Compliant ☐ Noncompliant ☒ Monitoring for medication adjustment

Medical Information

Please list any medical conditions (current and history):
None reported

MAJOR LIFE STRESSORS	Admits	Denies	Explanation (frequency, intensity, duration)
Problems at work/school (bullying, truancy, grades, etc.) **Current Grade:** 11th	✔		She gets in trouble for her impulsive behaviors like being disrespectful and verbally aggressive. She's had a few ISS this school year.
Learning/Developmental Disabilities/IDD/Autism **Able to read/write?** ✔ Yes ☐ No	✔		ADHD IEP for main subjects
Financial issues		✔	
Legal issues **Court ordered for treatment?** ☐ Yes ✔ No		✔	
BEHAVIOR CHANGES	**Admits**	**Denies**	**Explanation** (frequency, intensity, duration)
Deterioration in hygiene or grooming		✔	
Loss of energy/interest		✔	.
Social withdrawal/Relationship Issues		✔	
Irritability/Disruptive behaviors/Emotional outbursts	✔		Every other week she has emotional outburst or disruptive behaviors where she will yell, become verbally and physically aggressive, very impulsive.
Anxiety/Excessive worrying	✔		Anything regarding her phone or getting grounded will trigger her anxiety.

- *If panic attacks occur: Frequency?* 2x a month *Triggers?* School
- *Behaviors (racing heart, sweating, crying, etc)?* Crying & hyperventilating

☑ No change in sleep ☐ Increase in sleep ☐ Decrease in sleep Duration of symptoms:

SLEEP	Admits	Denies	Explanation (frequency, intensity, duration)
Difficulty falling asleep		✔	.
Waking throughout the night		✔	
Nightmares		✔	.
Hypersomnia		✔	

Total hours of sleep per night: 8-9 Total hours of sleep per day: 0 Total consecutive hours of sleep: 8-9

☐ No change in appetite ☑ Increase in appetite ☐ Decrease in appetite Duration of symptoms: _____

APPETITE	Admits	Denies	Explanation (frequency, intensity, duration)
Binge eating	☐	☑	
Purposefully skipping meals	☐	☑	
Extreme picky eating	☑	☐	She eats a lot of chicken and really avoids red meat.
Purging/use of laxatives	☐	☑	
Hoarding/hiding food	☐	☑	

(within last 3 months) Weight ↑ or ↓ How many lbs.? 20 in last 4 ☐ days ☐ weeks ☐ months

When a patient's screen indicates a possible need for eating disorder as a primary diagnosis, as indicated by 'yes' answers to any of the above questions – complete the below Eating Disorder Screening ☑ N/A

Does your weight affect your mood or the way you feel about yourself?
How often do you think about food/body weight in a day?
Are you trying to lose weight or be thinner?
Have you ever eaten in secrecy?
How often do you exercise?

PSYCHOSIS	Admits	Denies	Explanation (frequency, intensity, duration)
Hallucinations: ☐ AH ☐ VH ☐ Tactile ☐ Command		☑	
Delusions		☑	
Paranoid Ideations		☑	

☐ No lifetime experience/witness of trauma/abuse

TRAUMA	Current	Past (what age)	Reported?	Denies	Describe
Physical				X	
Emotional				X	
Have you ever been a victim of inappropriate touching and/or sexual assault/sexual abuse?	X		Yes		The patient states her boyfriend sexually assaulted her on 11/01/2025, which is why she feels suicidal.
Have you ever engaged in inappropriate touching of another person, or been accused of sexual assault?				X	
Do you engage in any compulsive sexual behavior?	X				She's run away to have intercourse, she records herself masturbating and sends them to strangers, she sends multiple nudes to males.
Other (neglect, witness to violence, significant losses)				X	

Police/CPS report required at this time? Name of person filing report:
☐ Yes ■ No
Case #:

In the last month, have you re-experienced the event in a distressing way? *(dreams, recollections, flashbacks, etc.)*			X

Any situations at home that require immediate attention? *(child/pet/etc.)* If yes, what action needs to be taken:

None reported

Was pregnancy/birth of patient traumatic? If yes, how? N/A

☐ No lifetime history of any violence/risk to others

AGGRESSION	Admits	Denies	Describe
Aggressive **ideations** ☐ 6 months ■ lifetime	☑	☐	MRE: She's mostly verbally aggressive when things don't go her way.
Aggressive **behaviors** ☐ 6 months ■ lifetime	☑	☐	MRE: She has impulsive physical aggression when upset.
Homicidal **threats** ☐ 6 months ☐ lifetime	☐	☑	MRE:
Homicidal **attempts** ☐ 6 months ☐ lifetime	☐	☑	MRE:
Homicidal **Plan** Access to means? ☐ Yes ☐ No	☐	☑	
Homicidal Intent	☐	☑	
Previous use of weapons	☐	☑	
Harm to self/others in a treatment setting	☐	☑	

Elopement History	Admits	Denies	Describe
Do you have a history of runaway behaviors? Skipping school or leaving without permission?	☑	☐	She ran away from home a few months ago to have sexual intercourse with someone.
Have you every eloped from a treatment facility?	☐	☑	

Military History (For Adults >18 years of age) ■ N/A	
Do you have any military experience:	If yes, in what branch did you serve?
Dates of Service:	Type of discharge:
Are you currently enrolled in the VA Health System?	
Have you experienced combat duty? If yes, list where and when.	
Did you experience any trauma while serving (to include sexual harassment or abuse)?	

SUBSTANCE ABUSE (check if ever used)

☑ Alcohol*	☑ Marijuana*	☐ Stimulants	☐ Opiates*	☐ OTCs	☐ Methamphetamine	☐ Hallucinogens
☐ Benzos*	☐ Methadone	☐ RX Pain meds	☐ Heroin	☐ Cocaine	☐ Sedatives	☐ Inhalants
☐ Tobacco	☐ Caffeine	☐ Synthetic*				

Substance (last 12 months)	Age of 1st use	Current amount	Current frequency	Current duration	Last use
Marijuana	16				
Alcohol	16				

Longest period of sobriety: Date of last period of sobriety:

Triggers for relapse:

Current withdrawal symptoms: ☐ None ☐ Nausea ☐ Tremor ☐ Sweating ☐ Agitation ☐ Body aches ☐ Weakness ☐ Diarrhea

History of: ☐ Withdrawal ☐ DTs ☐ Blackouts ☐ Seizures

When a patient's screen indicates a possible need for detox or substance abuse as a primary diagnosis, as indicated by yes answers to '*' questions – give the AUDIT and/or DAST for further information* (see below)

The Alcohol Use Disorders Identification Test (AUDIT) (Please complete even if patient indicates they don't consume alcohol)

Questions	0	1	2	3	4	Score
1) How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week	0
2) How many drinks containing alcohol, do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	0
3) How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	0
4) How often during the last year, have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	0
5) How often during the last year, have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	0
6) How often during the last year, have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	0
7) How often during the last year, have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	0
8) How often during the last year, have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	0

9) Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, within the last year	0
10) Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, within the last year	0
A score of >2 for Adolescents or >8 for Adults indicates harmful drinking behavior					**TOTAL**	0

Drug Abuse Screening Test (DAST) ☑ No drug use within past 12 months

Have you used drugs other than those required for medical reasons?	Yes	No
Have you abused prescription drugs?	Yes	No
Do you abuse more than one drug at a time?	Yes	No
Can you get through the week without using drugs (other than those required for medical reasons)?	Yes	No
Are you always able to stop using drugs when you want to?	Yes	No
Do you abuse drugs on a continuous basis?	Yes	No
Do you try to limit your drug use to certain situations?	Yes	No
Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
Do you ever feel bad about your drug abuse?	Yes	No
Does your boyfriend/girlfriend or parents ever complain about your involvement with drugs?	Yes	No
Do your friends or relatives know or suspect you abuse drugs?	Yes	No
Has drug abuse ever created problems between you and your boyfriend/girlfriend or parents?	Yes	No
Has any family member ever sought help for problems related to your drug use?	Yes	No
Have you ever lost friends because of your use of drugs?	Yes	No
Have you ever neglected your family or missed work because of your use of drugs?	Yes	No
Have you ever been in trouble at work/school because of drug abuse?	Yes	No
Have you ever been kicked out of school or lost a job because of drug abuse?	Yes	No
Have you gotten into fights when under the influence of drugs?	Yes	No
Have you ever been arrested because of unusual behavior while under the influence of drugs?	Yes	No
Have you ever been arrested for driving while under the influence of drugs?	Yes	No
Have you engaged in illegal activities to obtain drugs?	Yes	No
Have you ever been arrested for possession of illegal drugs?	Yes	No
Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	Yes	No
Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)?	Yes	No
Have you ever gone to anyone for help for a drug problem?	Yes	No
Have you ever been in hospital for medical problems related to your drug use?	Yes	No
Have you ever been involved in a treatment program specifically related to drug use?	Yes	No
Have you been treated as an outpatient for problems related to drug abuse?	Yes	No

Scoring: Each item in bold = 1 point 6 or more = substance use problem (abuse or dependence)	**SCORE:**	0

PREVIOUS TREATMENT			
Facility	**Level of Care**	**Dates**	**Diagnosis if known**
Methodist	IP	2023	
Primary Care Physician: The Children's Clinic		**Phone:** (870) 935-6012	☐ **ROI obtained**
Psychiatrist: The Practice: Hailey Neil		**Phone:** (870) 206-7300	☐ **ROI obtained**
Therapist: The Practice: Amber		**Phone:** (870) 206-7300	☐ **ROI obtained**

FAMILY HISTORY	**Admits**	**Denies**	**Explanation**
Substance Abuse	✔		Mother (Hx of alcoholism when manic)
Mental Illness	✔		Mother (Bipolar) & maternal side (anxiety)
Family HX of Suicide/Attempts	✔		Mother

If the patient was previously IP within the past 30 days (rapid re-admit), ask the following: ✔ N/A

1. What is your primary reason for re-admission?

☐ Assessment required for Outpatient care ☐ Need medication refilled ☐ Symptoms have worsened

☐ Other:

2. Did you follow your discharge plan? ☐ **YES** ☐ **NO; if no, then why not?**

☐ Did not have a follow-up appointment ☐ Too long of a waitlist for follow-up care ☐ Transportation issues

☐ Follow-up care was too costly ☐ Forgot about appointment ☐ Other:

Mental Status Exam

Level of consciousness: ■ Alert & Oriented ☐ Lethargic ☐ Intoxicated ☐ Unresponsive/unconscious

Orientation: ■ Person ■ Place ■ Date ■ Situation

Appearance: ■ Neat/well-groomed ☐ Disheveled ☐ Unclean ☐ Bizarre ☐ Deterioration of hygiene

Speech: ■ Normal ☐ Pressured ☐ Slurred ☐ Rambling ☐ Soft ☐ Slow ☐ Mute ☐ Monotone ☐ Incoherent

Behavior: ■ Cooperative ☐ Guarded ☐ Hostile ☐ Bizarre ☐ Psycho-motor agitation ☐ Psycho-motor retardation

Mood: ■ Depressed ☐ Anxious ■ Manic ☐ Appropriate ☐ Incongruent ☐ Distracted ☐ Guarded ☐ Angry ☐ Suspicious

Affect: ■ Congruent ☐ Restricted ☐ Flat ☐ Labile ☐ Inappropriate ☐ Incongruent ☐ Tearful

Thought Process: ☐ Logical ☐ Disorganized ☐ Loose associations ☐ Tangential ☐ Circumstantial ☐ Flight of ideas ■ Poor concentration ☐ Blocking ☐ Concrete

Judgement: ☐ Good ☐ Fair ■ Poor **Insight:** ☐ Good ☐ Fair ■ Poor

Eye Contact: ■ Good ☐ Fair ☐ Poor **Impulse Control:** ☐ Good ☐ Fair ■ Poor

Memory-Remote: ■ Good ☐ Fair ☐ Poor **Memory-Recent:** ■ Good ☐ Fair ☐ Poor

SUICIDAL BEHAVIOR

Actual Attempt:

A potentially self-injurious act committed with at least some wish to die, *as a result of act.* ***There does not have to be any injury or harm***, just the potential for injury or harm.

Have you had an actual suicide attempt? ☑ Yes ☑ No

If yes, please provide the following information for each: date of attempt, method of attempts, how was it stopped/intervened?

Have you engaged in non-suicidal self-injurious behavior? ☑ Yes ☐ No

If yes, please provide the following information for incidences in the last 3 months: date and method of self-harm.

She used an eyebrow razor on her wrist 3 months ago. She also scratches her wrist with her nails.

Aborted or Self-Interrupted Attempt:

When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior.

Have you ever had a suicide attempt aborted by another person or self-interrupted?

☐ Yes ☑ No **If yes, how many times has this occurred and when?**

Preparatory Acts or Behavior:

Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

Have you ever begun making preparatory acts, but did not carry out an actual attempt?

☑ Yes ☐ No **If yes, when and what were you doing?**

She kept a razor blade in her room with plans of cutting and killing herself.

SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) - Recent

Step 1: Identify Risk Factors

C-SSRS Suicidal Ideation Severity	Month
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	YES
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	YES
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	YES
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	YES
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*	YES

	Lifetime
C-SSRS Suicidal Behavior: ***"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"***	YES
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If "YES" Was it within the past 3 months?**	**Past 3 Months**

Activating Events:
- ■ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- □ Pending incarceration or homelessness
- □ Current or pending isolation or feeling alone

Treatment History:
- ■ Previous psychiatric diagnosis and treatments
- □ Hopeless or dissatisfied with treatment
- □ Non-compliant with treatment
- □ Not receiving treatment
- □ Insomnia

Other:
- □ _____
- □ _____
- □ _____

Clinical Status:
- □ Hopelessness
- □ Major depressive episode
- ■ Mixed affect episode (e.g. Bipolar)
- □ Command Hallucinations to hurt self
- □ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- ■ Highly impulsive behavior
- □ Substance abuse or dependence
- ■ Agitation or severe anxiety
- □ Perceived burden on family or others
- □ Homicidal Ideation
- ■ Aggressive behavior towards others
- □ Refuses or feels unable to agree to safety plan
- ■ Sexual abuse (lifetime)
- ■ Family history of suicide

□ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or ease of accessing

None reported

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:	External:
□ Fear of death or dying due to pain and suffering ■ Identifies reasons for living ☐ N/A ☐ _____	□ Belief that suicide is immoral, high spirituality □ Responsibility to family or others; living with family ■ Supportive social network of family or friends □ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior)

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	Month
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	2
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	5
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	4
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	3
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others couldn't go on and to end/stop the pain feeling) (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you living with the pain or how you were (0) Does not apply	3
Total Score	17

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Suicide Risk ☑ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** ☐ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	☑ Initiate local psychiatric admission process ☑ Stay with patient until transfer to higher level of care is complete ☑ Follow-up and document outcome of emergency psychiatric evaluation ☑ Directly address suicide risk, implementing suicide prevention strategies ☑ Develop Safety Plan
Moderate Suicide Risk ☐ Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** ☐ Suicidal **behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime)** **Or** ☐ Multiple risk factors and few protective factors	☐ Initiate local psychiatric admission process ☐ Stay with patient until transfer to higher level of care is complete ☐ Follow-up and document outcome of emergency psychiatric evaluation ☐ Directly address suicide risk, implementing suicide prevention strategies ☐ Develop Safety Plan
Low Suicide Risk ☐ Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** ☐ Modifiable risk factors and strong protective factors **Or** ☐ No reported history of Suicidal Ideation or Behavior	☐ Initiate local psychiatric admission process ☐ Follow-up and document outcome of emergency psychiatric evaluation ☐ Directly address suicide risk, implementing suicide prevention strategies ☐ Develop Safety Plan ☐ Discretionary Outpatient Referral

Step 5: Documentation

Risk Level: ☑ High Suicide Risk ☐ Moderate Suicide Risk ☐ Low Suicide Risk

Clinical Note:

Brief Clinical Observation

(Mental Status Information, Methods of Suicide Risk Evaluation)

The patient is alert & oriented x 4. She has a normal speech pattern & poor concentration. She has a depressed & manic mood and congruent affect. The patient has good eye contact and memory. She has poor impulse control, insight & judgement.

Brief Evaluation Summary

(Warning Signs, Risk Indicators, Protective Factors, Access to Lethal Means, Collateral Sources Used and Relevant Information on Obtained, Specific Assessment Data to Support Risk Determination, Rationale for Actions Taken and Not Taken)

The patient is presenting with mood disturbances & suicidal ideations. The patient has made plan to kill herself by cutting herself with a razor blade. The patient has a history of multiple manic behaviors such as impulsiveness, aggression, stealing, lying, and sexual behaviors. The patient is a danger to herself and is in need 24/7 acute care for stabilization.

☐ **Implemented Safety Plan (when applicable)**

☐ **Provided Crisis Line: 1-800-273-TALK (8255)**

SAFE-T Protocol with C-SSRS Completed By: Jasmine Parker, MA Date: 11/03/2025 Time: 09:56

Signature and Credentials

Discrepancies in Assessment

N/A

Woodridge of West Memphis
Stultz, Kennedy; F;
11/07/2008; 16Y
Huynh, Nga;
M/R: 62676; ACC: 1060006577
11/03/2025; 21:05

CLIENT NAME: Kennedy Stultz
CLIENT ID#: 62676

DATE: 11/03/2025
MD: Nga Huynh

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Please enter the score for the term which best describes the patient's condition.

0 = not assessed, 1 = not present, 2 = very mild, 3 = mild, 4 = moderate, 5 = moderately severe, 6 = severe, 7 = extremely severe

1. **SOMATIC CONCERN** Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not.	SCORE 1	10. **HOSTILITY** Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not infer hostility from neurotic defenses, anxiety, nor somatic complaints. (*Rate attitude toward interviewer under "uncooperativeness"*).	SCORE 1
2. **ANXIETY** Worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms.	SCORE 3	11. **SUSPICIOUSNESS** Brief *(delusional or otherwise)* that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances.	SCORE 1
3. **EMOTIONAL WITHDRAWAL** Deficiency in relating to the interviewer and to the interviewer situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation.	SCORE 1	12. **HALLUCINATORY BEHAVIOR** Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people.	SCORE 1
4. **CONCEPTUAL DISORGANIZATION** Degree to which the thought processes are confused, disconnected, or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of patient's subjective impression of his own level of functioning.	SCORE 1	13. **MOTOR RETARDATION** Reduction in energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only; do not rate on the basis of patient's subjective impression of own energy level.	SCORE 1
5. **GUILT FEELINGS** Over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety or neurotic defenses.	SCORE 2	14. **UNCOOPERATIVENESS** Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on basis of reported resentment or uncooperativeness outside the interview situation.	SCORE 1
6. **TENSION** Physical and motor manifestations of tension "nervousness", and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient.	SCORE 1	15. **UNUSUAL THOUGHT CONTENT** Unusual, odd, strange or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought processes.	SCORE 1
7. **MANNERISMS AND POSTURING** Unusual and unnatural motor benavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here.	SCORE 1	16. **BLUNTED AFFECT** Reduced emotional tone, apparent lack of normal feeling or involvement.	SCORE 1
8. **GRANDIOSITY** Exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation.	SCORE 1	17. **EXCITEMENT** Heightened emotional tone, agitation, increased reactivity.	SCORE 1
9. **DEPRESSIVE MOOD** Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints.	SCORE 6	18. **DISORIENTATION** Confusion or lack of proper association for person, place or time.	SCORE 1

Woodridge of West Memphis
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DISPOSITION

Guardian/Patient preferred level of care: Inpatient

Clinical Rationale for level of care chosen:

Suicidal Ideations & Manic episode

☑ **INPATIENT** ☐ **PARTIAL HOSPITALIZATION** ☐ **INTENSIVE OUTPATIENT**

☐ **COMMUNITY REFERRAL (facility/agency name):**

Primary Provisional Diagnosis: F31.9

Assessment Completed By: Jasmine Parker, MA **Date:** 11/03/2025 **Time:** 09:56

Signature and Credentials

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