BEHAVIORAL HEALTH

INITIAL CLINICAL REVIEW FORM

(Please address each area. An incomplete form may result in a delay of your request.)
Submit completed form to: MCO EMAIL/FAX #

Date Form Completed:

FACILITY INFORMATION

Name of Facility:
Out of State Facility (Y/N):
If Yes: Must attach denial letters from in state facilities.
National Provider ID:
Address/Service Location:
Facility/Program Contact (Name):
Phone:
Fax:
Level of Care Requested (include Billing Code):
Date of Admission:
Requested Dates of Service:
Requested Number of Service Units:

Is member currently in detention (Yes/No)?
(If yes: 1 day business TAT required for RTC LOC requests.)
If yes, Name of location:
Is member involved with Children, Youth and Families Department (CYFD) Juveniles Justice Services (JJS) (Y/N)?
If yes, JJS Staff Person Name/ Phone Number:
MEMBER INFORMATION

*Please complete applicable fields.

Member Name (First/Last):
Member ID or SSN:
Member DOB:
Member Age:
Name of Legal Guardian:
Guardian Address:
Guardian Phone:
Consumer’s currently lives with (homeless, parents/siblings):
Is the member involved with CYFD-CPS (Yes/No)?
Is the member currently in custody of CYFD (Yes/No)?
If yes, CYFD SW Name/Phone:
Is the member involved with Adult Protective Services?
If yes, APS SW Name/Phone:
Is member involved with CYFD Juveniles Justice Services (JJS) (Y/N)?
If yes, JJS Name/ Phone:
Power of Attorney (POA) Name/Phone:
Treatment Guardian Name/Phone:
DD Waiver Status:

DSM DIAGNOSES

Admitting DSM Diagnosis (Include DSM codes):

Historical DSM Diagnosis (Clarify what is the source of information.):

Description of Medical Needs (Including DME and chronic/co-morbid conditions):
PRECIPITANT FOR TREATMENT/ADMISSION

Has parent/guardian agreed to participate in Treatment Planning and Therapy Sessions (Yes/No)?
If no, why not?
Is the member medically stable (Yes/No)?
Member referred to this facility by:

PRECIPITANT FOR REQUEST (Describe current behaviors that justify LOC):

Interventions in the past year that have been unsuccessful and led to the need for LOC (Treatment History):

Most Recent MH/SA Provider:
Is the member active in a CSA?
If yes, what CSA?

History of Out-of-Home Placements:

Family/Guardian and/or Primary Support in the past year (including participation in lower LOC treatment, if parent/guardian has not been involved please give reason):

Family History of Mental Health issues:
DESCRIBE CURRENT FUNCTIONING IN OTHER LIFE DOMAINS (Including school program, attendance, participation in outpatient therapy including adherence to medications, leisure activities):

Language/Spiritual/Cultural Factors (How will these affect treatment engagement? Be sure to incorporate into treatment plans):

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MENTAL STATUS EXAM

MSE was completed by (Name):
Date Completed:
If not completed, why not?
Appearance and behavior (posture, gestures, attire, facial expressions and speech):
Attention (normal, altered, impaired):
Mood (normal, euphoric, agitated, sad, etc.):
Affect (appropriate, inappropriate, flat, etc.):
Perception (hallucinations, delusions, etc.):
Thought Content/Process (logical, de-realizations, SI/HI, etc.):
Orientations (time, person, place, circumstances):
Insight (good/fair/poor/absent):
Activities of Daily Living (i.e. within normal limits, impaired):
Sleep (e.g. disturbed, early morning awakening, etc.):

____________________

RISK ASSESSMENT

Does the member currently have suicidal or homicidal ideation?
Means:
Motives:
Plan/Intent:
Current aggression that justifies LOC:
Active psychosis (describe):
Other dangerous or self-injurious behaviors:

Does the member have a current/history of substance abuse (SA)?
SA Frequency/Duration:
SA Last use:
Is there any known history of substance use by family members?

Does the member have a history of domestic violence (witness or harm to/by family members)?
Does the member have access to guns in the home?
Is the member willing/able to contract for safety?

CURRENT MEDICATIONS

(List all MH/SA and Medical)
Name:
Dose:
Frequency Taken:
Date Started:
Prescriber:

Is member adherent to medication (Yes/No)?
If no, why not?

Response to medication:
INITIAL TREATMENT PLAN

Summary of Treatment Plan (What are the identified problem areas that will be a focus of treatment?)

Other factors/pertinent information impacting treatment:

DISCHARGE PLAN

Current ELOS (estimated length of stay):

What is the preliminary discharge plan?