Amerigroup RealSolutions in healthcare

https://providers.amerigroup.com

Behavioral Health Initial Review Form

This form is for inpatients, the *Partial Hospitalization Program* and the *Intensive Outpatient Program*.

Please submit this form on the provider website, https://providers.amerigroup.com/GA, within two hours of admission or prior to admission for nonurgent services.

Today's date:	
General information	
Level of care: ☐ Inpatient psychiatric ☐ Inpatient detoxification	☐ Intensive outpatient program ☐ Partial hospitalization program
Member name:	
Member DOB:	
Member identification number or reference number:	
Facility account number:	
Member address:	
Member phone number:	
Primary spoken language:	
For child/adolescent, name of parent or guardian:	
Amerigroup Community Care has permission to use all listed contact numbers for further discussions about member's health care.	☐ Yes ☐ No
Name of utilization review contact:	
Utilization review contact phone number:	
Utilization review contact fax number:	
Admit date:	☐ Voluntary ☐ Involuntary
Name of admitting facility:	
Facility NPI/Amerigroup provider number:	
Attending physician name:	
Attending physician phone number:	
Provider NPI/Amerigroup provider number:	
Facility unit:	
Facility phone number:	
Discharge planner name:	
Discharge planner phone number:	

Diagnoses (psychiatric, chemical dependency and medical)

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Reason for admission

Why is treatment needed now? Be specific.

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Risk assessment

Is the member stable (no risk for suicide, homicide or psychosis)? ☐ Yes ☐ No

If no, please explain. Include reasons why admission is medically necessary.

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Current legal issues

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Substance abuse or dependence

Current urinary analysis/lab results and use pattern (substances, last use, frequency, duration, sober history, vitals, etc.):

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For substance use disorders, please complete the following information:
current assessment of American Society of Addiction Medicine (ASAM) criteria

Dimension (describe or give symptoms):	Risk rating:
Dimension one — acute intoxication and/or withdrawal potential: (Include vitals and withdrawal symptoms.) _____ _____ _____	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension two — biomedical conditions and complications: _____ _____ _____	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension three — emotional, behavioral or cognitive complications: _____ _____ _____	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension four — readiness to change: _____ _____ _____	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe

Current assessment of ASAM criteria (continued)	
Dimension (describe or give symptoms):	Risk rating:
Dimension five — relapse, continued use or continued problem potential: _____ _____ _____	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension six — recovery living environment: _____ _____ _____	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning? _____ _____ _____ _____ _____ _____ _____	
Previous treatment	
Please note the dates of service, provider and facility name, medications, specific treatment/levels of care, and adherence for previous treatments. In addition, attach current psychological report. (Be specific: inpatient, rehabilitation, partial hospitalization program, inpatient/outpatient program, inpatient family intervention, community support individual, intensive community supports, etc.) _____ _____ _____ _____ _____ _____ _____ _____	

Current treatment plan

Please list all standing medications and their doses.

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Please list all as-needed (PRN) medications administered (not ordered).

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Please list other treatment and/or interventions planned (including when family therapy is planned):

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Support system

Note coordination activities with case managers, family, community agencies, etc. If case is open with another agency, provide the agency, phone number and case number.

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Readmission

Has the member been readmitted within the last 30 days? ☐ Yes ☐ No

If yes and readmission was to the discharging facility, what part of the discharge plan did not work and why?

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Initial discharge plan

Be sure to list names, addresses and phone numbers of providers. Also, include whether the member can return to current residence.

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Days requested for this review:

Expected length of stay from today:

Submitted by:

Print: _____

Signature: _____

Phone number: