



## Behavioral health initial review (For inpatient, residential treatment center, partial hospitalization program and intensive outpatient program)

**Please fax to 1-877-434-7578 within two hours of admission or prior to admission for non-urgent services.**

Today's date:		
<b>Contact information</b>		
Level of care: Inpatient psych: <input type="checkbox"/> Inpatient detox: <input type="checkbox"/> Inpatient chemical dependency: <input type="checkbox"/> Psychiatric RTC: <input type="checkbox"/> Chemical dependency RTC: <input type="checkbox"/> PHP: <input type="checkbox"/> IOP: <input type="checkbox"/>		
Member name:	Member ID or reference number:	Member date of birth:
Member address:		Member phone number:
Hospital account number:	For child/adolescent, name of parent/guardian:	Primary spoken language:
Name of utilization review (UR) contact:	UR phone number:	
	UR fax number:	
Admit date:	Voluntary or involuntary?	
Admitting facility name:	Facility provider number or NPI:	
Attending physician first and last names:	Attending physician phone number:	
Provider number or NPI:	Facility unit:	Facility phone number:
Discharge planner name:	Discharge planner phone number:	
<b>Diagnoses (psychiatric, chemical dependency and medical):</b>		

Important Note: You are not permitted to use or disclose Protected Health Information about individuals that you are not currently treating or have enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

Amerivantage is an HMO plan with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in Amerivantage depends on contract renewal.



**Precipitant to admission**  
 Be specific. Why is the treatment needed now?

**Risk assessment**  
 Include medical necessity reasons for admission.

**Current legal issues**

**Substance abuse or dependence**  
 Current UA/lab results and use pattern (substances, last use, frequency, duration, sober history, vitals)

**For substance use disorders, please complete the following additional information:**

Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (Describe or give symptoms)	Risk Rating
Dimension 1 (Acute intoxication and/or withdrawal potential. Include vitals, withdrawal symptoms):	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 2 (biomedical conditions and complications)	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 3 (emotional, behavioral or cognitive complications)	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>



Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (Describe or give symptoms)	Risk Rating
Dimension 4 (readiness to change)	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 5 (relapse, continued use or continued problem potential)	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 6 (recovery living environment)	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
<p>If any ASAM dimensions have moderate or higher-risk ratings, how are they being addressed in treatment or discharge planning?</p>	
Previous treatment	
<p>Include provider name, facility name, medications, specific treatment/levels of care and adherence.</p>	
Current treatment plan	
<p>Standing medications:</p>	
<p>As-needed (PRN) medications administered (not ordered):</p>	
<p>Other treatment and/or interventions planned (including when family therapy is planned):</p>	



**Support system**

(Include coordination activities with case managers, family, community agencies, etc. If case is open with another agency, name the agency, phone number and case number.)

**Readmission within 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?

**Initial discharge plan**  
List name and number of discharge planner and include whether the member can return to current residence.

**Days requested or expected length of stay from today:**

Days requested or expected length of stay from today:

Submitted by:

Phone number: