



**Behavioral health concurrent review**

**(For inpatient, residential treatment center, partial hospitalization program and intensive outpatient program)**

**Please fax to 1-877-434-7578 on the last authorized day.**

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:
Facility contact name and phone number (if changed):		Admitting facility name:
Facility provider number or NPI:	Facility unit and phone number (if changed since initial review):	
<b>Diagnoses (document changes only):</b>		
<b>Risk assessment</b>		
In the past 24 to 48 hours, has the member shown suicidal or homicidal thoughts or plans, physical aggression to self or others, or command auditory hallucinations? On close observation, has the member shown drug and/or alcohol withdrawal symptoms or comorbid health concerns?		
If yes, explain:		

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 Washington Medicaid program. Enrollment in Amerivantage depends on contract renewal.



**Lab results**

**Medications**

List current medications and any changes with dates. Include medications for physical conditions. If medications require prior authorization, indicate how this is being addressed. Indicate as-needed [PRN] medications actually administered and when.

Summary of family therapy (date, time, who participated, outcome):

Summary of nursing notes:

Summary of M.D. notes:

Other treatment plan changes or assessments (Include results of chemical dependency assessment, medical assessments or treatments):

**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"/>



Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (describe or give symptoms)	Risk rating
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"/>
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>	
<p>Response to treatment:</p>	
<p>Involvement in treatment or discharge planning of member, family/guardian(s), outpatient providers or other identified supports:</p>	



**Discharge planning**

(Note changes, barriers to discharge planning in these areas and plan for resolving barriers. If a recent readmission, indicate what is different about the plan from last time.)

Housing issues:

Psychiatry:

Therapy and/or counseling:

Medical:

Wraparound services:

Substance abuse services:

**Was post-hospital discharge appointment scheduled?**

Yes  No

**Appointment date:**

Days requested or expected length of stay from today:

Submitted by:

Phone number: