American Behavioral

AMERICAN BEHAVIORAL INITIAL REVIEW FAX FOR MENTAL HEALTH TREATMENT
IN-NETWORK FACILITY ONLY
Telephone: (205) 871-7814
Fax Completed Information To: (205) 868-9625

Patient Name:	**Contract Name**	**DOB:**	**Date of Review:**
Patient Phone # *(Required)*:	**ID#:**		

Does the Patient Have Any Additional Coverage? ☐ Yes ☐ No

Primary: _____

Secondary: _____

Other:

Facility Name:

Date of Admission:

Attending MD:

Phone #:

Program Type: ☐ IP ☐ PHP ☐ IOP (Verify Coverage) ☐ Residential (Verify Coverage)

For PHP or IOP, please check days patient is attending: ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Estimated Length of Stay:

Prompt For Help: Pt's Motivation To Seek Treatment:

History:

1. **How was patient admitted (e.g. Emergency Department, direct admit, step-down, etc.)?**
2. **Legal issues (e.g. court hold, etc.):**
3. **If disabled, on what basis?**

Stressors: Life Role Dysfunction (School, Employment, Financial, Legal And How Severe) With Examples:

MD Orders (Medications, Precautions, Type of Unit):

Defined Tx Plan:

Physical & Mental Status Assessment:

Admitting VS: T_____P_____RR_____B/P_____WT_____ Recent Weight Change?_____

Social/Family History:

Discharge Plan:

***Required*: After Care Plan (Including Follow-up Instructions and D/C Medications):**

***Required*: Please Send a Copy of the Face Sheet and a Copy of the H & P With the Completed Form**

UR Contact: **Phone #:** **Fax #:**

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Date of Next Review: **Total Days Certified:**

Payment of benefits is subject to eligibility at the time services are rendered according to the terms of the benefit contract. ***Revised 12/22/16***

Supersedes Revision(s) Dated: 09/11/12; 07/12/12; 10/03/13

Patient Name:		**ID #:**
DIAGNOSTIC ASSESSMENT		
	Presenting Complaints or Conditions	**Notes**
Risk (Intent, Thought, Means, Plan)	Suicide Homicide Other Risky Behavior(s)	
Mood	Normal Depressed Anxious Manic Hypomanic Other	
Thoughts	Normal Suspicious Hallucinations --Auditory --Tactile --Visual --Gustatory --Olfactory Delusions Other	
Sleep	Undisturbed Insomnia Frequent Awakening Difficulty Falling Asleep Early AM Awakening Hypersomnia Nightmares Other	
Behavior	Aggressive Compulsive Reckless Other	
Appetite	Good Bulimia Anorexia	
ADL	Hygiene Bathing Other	
NOTES:		