



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

<b>Patient Name:</b>	<b>Contract Name</b>	<b>DOB:</b>	<b>Date of Review:</b>
<b>Patient Phone # (Required):</b>	<b>ID#:</b>		
<b>Does the Patient Have Any Additional Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Primary:</b> _____ <b>Secondary:</b> _____ <b>Other:</b> _____		<b>Facility Name:</b> <b>Date of Admission:</b> <b>Attending MD:</b> <b>Phone #:</b>	
<b>Program Type:</b> <input type="checkbox"/> IP <input type="checkbox"/> PHP <input type="checkbox"/> IOP (Verify Coverage) <input type="checkbox"/> Residential (Verify Coverage) <i>For PHP or IOP, please check days patient is attending:</i> <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun			
<b>Estimated Length of Stay:</b>			
<b>Prompt For Help: Pt's Motivation To Seek Treatment:</b>			
<b>History:</b>			
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?			
<b>Stressors: Life Role Dysfunction (School, Employment, Financial, Legal And How Severe) With Examples:</b>			
<b>MD Orders (Medications, Precautions, Type of Unit):</b>			
<b>Defined Tx Plan:</b>			
<b>Physical &amp; Mental Status Assessment:</b>			
Admitting VS: T _____ P _____ RR _____ B/P _____ WT _____			Recent Weight Change? _____
<b>Social/Family History:</b>			
<b>Discharge Plan:</b>			
<b>Required:</b> After Care Plan (Including Follow-up Instructions and D/C Medications):			
<b>Required:</b> Please Send a Copy of the <b>Face Sheet</b> and a Copy of the <b>H &amp; P</b> With the Completed Form			
<b>UR Contact:</b>		<b>Phone #:</b>	<b>Fax #:</b>
<b>FOR AMERICAN BEHAVIORAL USE ONLY</b>			
<b>Date of Next Review:</b>		<b>Total Days Certified:</b>	

**CONFIDENTIALITY NOTE:** The information contained in this facsimile is legally privileged and confidential information intended only for the use of the individual or entity named above. If the reader of the message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copy of this facsimile is strictly prohibited. If you have received this facsimile in error, please immediately notify us by telephone and return the original message to us at the address at the top of the page via the United States Postal Service.

Payment of benefits is subject to eligibility at the time services are rendered according to the terms of the benefit contract.  
 Supersedes Revision(s) Dated: 09/11/12; 07/12/12; 10/03/13

Revised 12/22/16

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

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