

AMERICAN BEHAVIORAL CONTINUED STAY REVIEW FAX FOR SUBSTANCE ABUSE TREATMENT

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 Admission:</b> |
| <b>Patient Phone # (Required):</b>                                                                                                   | <b>ID #:</b>                                                                                               |                          |                           |
| <b>Facility Name:</b>                                                                                                                | <b>Program Type:</b> <input type="checkbox"/> IP <input type="checkbox"/> PHP <input type="checkbox"/> IOP | <b>Attending MD:</b>     |                           |
| <b>Date of Review:</b>                                                                                                               | <b>Estimated Length of Stay:</b>                                                                           | <b>Phone #:</b>          |                           |
| <b>1. Present Mental Status:</b>                                                                                                     |                                                                                                            |                          |                           |
| <b>2. Any Current Cravings Noted?</b> YES       NO                                                                                   |                                                                                                            |                          |                           |
| <b>3. Any Signs or Symptoms of Withdrawal?</b> YES       NO <b>If So, Please Explain:</b>                                            |                                                                                                            |                          |                           |
| <b>4. Urine Drug Screen</b> YES       NO <b>Date:</b> <b>Results:</b>                                                                |                                                                                                            |                          |                           |
| <b>5. Are Vital Signs Stable?</b> YES       NO <b>If Not, Please Explain:</b>                                                        |                                                                                                            |                          |                           |
| <b>6. Changes In Medications:</b>                                                                                                    |                                                                                                            |                          |                           |
| <b>7. Please List Any New Clinical Information (i.e. Psych Testing Results, Axis Changes, Etc.)</b>                                  |                                                                                                            |                          |                           |
| <b>8. Are There Any Life-Threatening Toxic Effects?</b> YES       NO <b>If So, Please List:</b>                                      |                                                                                                            |                          |                           |
| <b>TREATMENT INFORMATION AND COMPLIANCE—If The Answer To Any of The Below Is “No,” Please Explain</b>                                |                                                                                                            |                          |                           |
| <b>1. Has Patient Found a Sponsor?</b> YES       NO <b>If So, Is The Sponsor</b> Temporary     Permanent                             |                                                                                                            |                          |                           |
| <b>2. How Many Days Per Week Is The Patient Required To Attend Treatment?</b> <b>Is The Patient Attending All Days?</b> YES       NO |                                                                                                            |                          |                           |
| <b>3. Has Patient Completed And Turned In All Required Work?</b> YES       NO                                                        |                                                                                                            |                          |                           |
| <b>4. Is Patient Participating And Verbalizing In Group/Individual Therapy?</b> YES       NO                                         |                                                                                                            |                          |                           |
| <b>5. Please Describe Overall Progress In Therapy:</b>                                                                               |                                                                                                            |                          |                           |
| <b>6. Has Patient Attended Required Outside AA Meetings?</b> YES       NO                                                            |                                                                                                            |                          |                           |
| <b>7. Can Effective Treatment Be Rendered At A Lower Level of Care?</b> YES       NO                                                 |                                                                                                            |                          |                           |
| <b>PATIENT SUPPORT SYSTEM</b> Single           Married           Divorced           Widowed                                          |                                                                                                            |                          |                           |
| <b>What Is Patient Support System At This Time?</b>                                                                                  |                                                                                                            |                          |                           |
| <b>Has The Family/Support System Attended Any Family Education And Support Sessions?</b> YES       NO                                |                                                                                                            |                          |                           |
| <b>Discharge Plan:</b>                                                                                                               |                                                                                                            |                          | <b>Discharge Date:</b>    |
| <b>Post-Discharge, What Will Patient’s Living Arrangement Be (i.e. home, halfway house, etc.)?</b>                                   |                                                                                                            |                          |                           |
| <b>Required:</b> After Care Plan (Including Follow-up Instructions and D/C Medications):                                             |                                                                                                            |                          |                           |
| <b>Required:</b> Please Send a Copy of the Face Sheet and a Copy of the H & P With the Completed Form                                |                                                                                                            |                          |                           |
| <b>UR Contact:</b>                                                                                                                   | <b>Phone #:</b>                                                                                            | <b>Fax #:</b>            |                           |
| <b>FOR AMERICAN BEHAVIORAL USE ONLY</b>                                                                                              |                                                                                                            | <b>SA Benefit:</b>       |                           |
| <b>PHP Days Used:</b>                                                                                                                | <b>IOP Days Used:</b>                                                                                      | <b>Next Review Date:</b> | <b>RN:</b>                |



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*Payment of benefits is subject to eligibility at the time services are rendered according to the terms of the benefit contract.*

**Revised 06.06.2012**