AMERICAN BEHAVIORAL CONTINUED STAY REVIEW FAX FOR MENTAL HEALTH TREATMENT
Telephone: (205) 871-7814
Fax Completed Information To: (205) 868-9625

Patient Name: **Patient Phone # *(Required)*:**	**Contract Name:** **ID#:**	**DOB:**	**Date of Admission:**
Facility Name: **Date of Review:**	**Program Type:** IP PHP IOP **Estimated Length of Stay:**	**Attending MD:** **Phone #:**	
Key Symptoms/Behaviors Targeted by Current Treatments:			
Clinical Progress or Regress Since Last Review/Other Problems Not Cited Above:			
Prior Treatment History:			
Social/Family History:			
History of ETOH & Other Psychoactive Substances: **ETOH Level:** **Drug Screens:** **Toxicity Screens:**			
MD Orders (Medications, Precautions, Type of Unit):			
Physical & Mental Status Assessment: **Current VS: T_____P_____RR_____B/P_____HT_____WT_____** **Recent Weight Change?**			
Clinical Factor(s) That Make Lower Levels of Care (e.g. Rx & Individual/Family Therapy, Etc.) Either Unsafe or Unfeasible:			
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 #:**			
FOR AMERICAN BEHAVIORAL USE ONLY **Date of Next Review:** **Total Days Certified:**			

American Behavioral

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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.

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