American Behavioral ®

AMERICAN BEHAVIORAL INITIAL 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 Review:**

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

Primary: ______________________________

Secondary: ______________________________

Other:

Is the Patient a Licensed Practitioner (eg., RN, LPN, etc.) ☐ Yes ☐ No

If Yes, Specify Licensure: ____________

Has the State Licensure Board Been Notified? ☐ Yes ☐ No

Does the Patient's Employment Cause Him/Her to Fall Under DOT Regulations? ☐ Yes ☐ No

Facility Name:

Date of Admission:

Attending MD:

Phone #

Program Type: ☐ IP ☐ PHP ☐ IOP

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

Estimated Length of Stay:

Admitting Diagnosis/AXIS: **I.** **II.** **III.** **IV.** **V.**

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

History:

1. **How was patient admitted (e.g. ER, 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:

Chemical Or ETOH Use:

Urine Drug Screen: **Toxicity Screen:** **ETOH Level:**

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 #:**

FOR AMERICAN BEHAVIORAL USE ONLY

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

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. ***Revised 10/03/13***

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

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 Delusions --Auditory --Tactile, --Visual --Gustatory Olfactory 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:		

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