American Behavioral

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** ☐ **Residential**
Estimated Length of Stay:	**Attending MD:**	**Attending MD Phone #:**
Key Symptoms/Behaviors Targeted by Current Treatments:		
Clinical Progress or Regress Since Last Review/Other Problems Not Cited Above:		
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:		
UR Contact:	**Phone #:**	**Fax #:**
FOR AMERICAN BEHAVIORAL USE ONLY **Date of Next Review:**	**Total Days Certified:**	

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:		