



American Behavioral
AMERICAN BEHAVIORAL INITIAL REVIEW FAX FOR SUBSTANCE ABUSE TREATMENT
 Telephone: (205) 871-7814
 Fax Completed Information To: (205) 868-9625

Today's Date:		Patient Name		
Patient ID Number:		Patient DOB:	Patient Phone # (Required) :	
Does the Patient Have Any Additional Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the Patient a Licensed Practitioner (eg., RN, LPN, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary: _____		If Yes, Specify Licensure: _____		
Secondary: _____		Has the State Licensure Board Been Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other: _____		Professional Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		
VIVA Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Admission:	Admit Type	
Admitted From: <input type="checkbox"/> Emergency Department <input type="checkbox"/> Home <input type="checkbox"/> Boarding Home <input type="checkbox"/> SNF		<input type="checkbox"/> Emergency Department <input type="checkbox"/> Direct Admission <input type="checkbox"/> Walk In		
<input type="checkbox"/> Other (Please Specify):				
Facility Name:		Freestanding Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Program Type: <input type="checkbox"/> IP Detox <input type="checkbox"/> IP Rehab <input type="checkbox"/> Residential <input type="checkbox"/> PHP <input type="checkbox"/> IOP				
Estimated Length of Stay:	Attending MD:		Attending MD Phone #:	
UR Contact:		Phone #	Fax #	
*** Required: Please Send a Copy of the Face Sheet, Psychosocial Assessment, and H & P With the Completed Form ***				
Admitting Diagnosis/AXIS:		I.	IV.	
		II.	V.	
		III.		
Stage of Change		As Exemplified By:		
<input type="checkbox"/> Precontemplation Stage				
<input type="checkbox"/> Contemplation Stage				
<input type="checkbox"/> Preparation Stage				
<input type="checkbox"/> Action Stage				
<input type="checkbox"/> Maintenance Stage				
Mental Health/Chemical Dependency Treatment History				
Previous Mental Health Treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Previous Substance Abuse/Chemical Dependency Treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Family History of Mental Health Treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Family History of Substance Abuse/Chemical Dependency Treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Details:				
Medical History				
History of Seizures?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
History of Cardiac Or Other Medical Condition(s)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Please Specify Medical Condition(s):				
Current Medications				
<i>Name</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Route</i>	<i>Date of Last Dose</i>

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

Revised 10/03/13

Patient Name:			Patient DOB:			
Support System						
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed						
Is Patient Living W/Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Is a Support System in Place? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, Who?						
Stressors: Life Role Dysfunction (School, Employment, Financial, Legal And How Severe) With Examples:						
Physical & Mental Status Assessment:						
Admitting VS:						
T _____ P _____ RR _____ B/P _____ HT _____ WT _____						
Current S/S Of Withdrawal:			Life-Threatening Toxic Effects:			
Chemical Or ETOH Use						
DAST-10 Score:		AUDIT Score:		Blood Alcohol Level:		
*** Drug(s) of Choice ***						
<i>Alcohol</i>	<i>Benzodiazepines</i>	<i>Opiates</i>		<i>Barbiturates</i>	<i>Stimulants</i>	
<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Whiskey <input type="checkbox"/> Other (Please Specify):	<input type="checkbox"/> Ativan <input type="checkbox"/> Klonopin <input type="checkbox"/> Librium <input type="checkbox"/> Valium <input type="checkbox"/> Xanax <input type="checkbox"/> Other (Please Specify):	<input type="checkbox"/> Actiq <input type="checkbox"/> Codeine <input type="checkbox"/> Darvocet <input type="checkbox"/> Darvon <input type="checkbox"/> Demerol <input type="checkbox"/> Dilaudid <input type="checkbox"/> Duragesic <input type="checkbox"/> Fentanyl <input type="checkbox"/> Hydrocodone <input type="checkbox"/> Heroin <input type="checkbox"/> Lorcet	<input type="checkbox"/> Lortab <input type="checkbox"/> Methadone <input type="checkbox"/> Morphine <input type="checkbox"/> Opium <input type="checkbox"/> Oxycodone <input type="checkbox"/> Oxycotin <input type="checkbox"/> Percocet <input type="checkbox"/> Percodan <input type="checkbox"/> Stadol <input type="checkbox"/> Talwin <input type="checkbox"/> Vicodin <input type="checkbox"/> Other (Please Specify):	<input type="checkbox"/> Alurate (Aprobarbital) <input type="checkbox"/> Amytal (Amobarbital) <input type="checkbox"/> Brevital (Methohexital) <input type="checkbox"/> Butisol (Butabarbital) <input type="checkbox"/> Fioricet/Fiorinal (Butalbital) <input type="checkbox"/> Luminal (Phenobarbital) <input type="checkbox"/> Mebaral (Mephobarbital) <input type="checkbox"/> Nembutal (Pentobarbital) <input type="checkbox"/> Pentothal (Thiopental) <input type="checkbox"/> Seconal (Secobarbital) <input type="checkbox"/> Other (Please Specify):	<input type="checkbox"/> Adderall <input type="checkbox"/> Cocaine <input type="checkbox"/> Concerta <input type="checkbox"/> Cylert <input type="checkbox"/> Dexedrine <input type="checkbox"/> Focalin <input type="checkbox"/> Metadate <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Ritaline <input type="checkbox"/> Straterra <input type="checkbox"/> Vyvanse <input type="checkbox"/> Other (Please Specify):	<input type="checkbox"/> DMT <input type="checkbox"/> Ecstasy <input type="checkbox"/> Ketamine <input type="checkbox"/> LSD <input type="checkbox"/> Marijuana <input type="checkbox"/> PCP <input type="checkbox"/> Peyote <input type="checkbox"/> Psilocybin (Mushrooms) <input type="checkbox"/> Other (Please Specify):
Amount:	Amount:	Amount:		Amount:	Amount:	
Route:	Route:	Route:		Route:	Route:	
Date of First Use:	Date of First Use:	Date of First Use:		Date of First Use:	Date of First Use:	
Date of Last Use:	Date of Last Use:	Date of Last Use:		Date of Last Use:	Date of Last Use:	
MD Orders (Medications, Precautions, Unit Type)						
Defined Discharge Plan						
*** FOR AMERICAN BEHAVIORAL USE ONLY ***						
Date of Next Review:			Total Days Certified:			

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