American Behavioral

AMERICAN BEHAVIORAL INITIAL REVIEW FAX FOR SUBSTANCE ABUSE TREATMENT
IN NETWORK FACILITIES ONLY
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? ☐ 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

Professional Program? ☐ Yes ☐ No

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

Date of Admission:	**Admit Type** ☐ Emergency Department ☐ Direct Admission ☐ Walk In

Admitted From: ☐ Emergency Department ☐ Home ☐ Boarding Home ☐ SNF
☐ Other (Please Specify):

Facility Name:	**Freestanding Facility?** ☐ Yes ☐ No

Program Type: ☐ IP Detox ☐ IP Rehab ☐ PHP ☐ IOP (Verify Coverage) ☐ Residential (Verify Coverage)
For PHP or IOP, please check days patient is attending: ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

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 ***

Stage of Change **As Exemplified By:**

☐ Precontemplation Stage
☐ Contemplation Stage
☐ Preparation Stage
☐ Action Stage
☐ Maintenance Stage

Mental Health/Chemical Dependency Treatment History

Previous Mental Health Treatment?	☐ Yes	☐ No
Previous Substance Abuse/Chemical Dependency Treatment?	☐ Yes	☐ No
Family History of Mental Health Treatment?	☐ Yes	☐ No
Family History of Substance Abuse/Chemical Dependency Treatment?	☐ Yes	☐ No

Details:

Medical History

History of Seizures?	☐ Yes	☐ No
History of Cardiac Or Other Medical Condition(s)?	☐ Yes	☐ No

Please Specify Medical Condition(s):

Current Medications

Name	*Dosage*	*Frequency*	*Route*	*Date of Last Dose*

Payment of benefits is subject to eligibility at the time services are rendered according to the terms of the benefit contract. ***Revised 01/16/17***
Supersedes Revision(s) Dated: 09/11/12; 07/12/12; 10/03/13, 12/22/16

Patient Name:	**Patient DOB:**

Support System

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Is Patient Living W/Spouse? ☐ Yes ☐ No

Is a Support System in Place? ☐ Yes ☐ 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: Urine Drug Screen:

***** Drug(s) of Choice *****

Alcohol	*Benzodiazepines*	*Opiates*	*Barbiturates*	*Stimulants*	*Hallucinogens*
☐ Beer ☐ Wine ☐ Whiskey ☐ Other (Please Specify):	☐ Ativan ☐ Klonopin ☐ Librium ☐ Valium ☐ Xanax ☐ Other (Please Specify):	☐ Actiq ☐ Codeine ☐ Darvocet ☐ Darvon ☐ Demerol ☐ Dilaudid ☐ Duragesic ☐ Fentanyl ☐ Hydrocodone ☐ Heroin ☐ Lorcet ☐ Lortab ☐ Methadone ☐ Morphine ☐ Opium ☐ Oxycodone ☐ Oxycontin ☐ Percocet ☐ Percodan ☐ Stadol ☐ Talwin ☐ Vicodin ☐ Other (Please Specify):	☐ Alurate (Aprobarbital) ☐ Amytal (Amobarbital) ☐ Brevital (Methohexital) ☐ Butisol (Butabarbital) ☐ Fioricet/Fiorinal (Butalbital) ☐ Luminal (Phenobarbital) ☐ Mebaral (Mephobarbital) ☐ Nembutal (Pentobarbital) ☐ Pentothal (Thiopental) ☐ Seconal (Secobarbital) ☐ Other (Please Specify):	☐ Adderall ☐ Cocaine ☐ Concerta ☐ Cylert ☐ Dexedrine ☐ Focalin ☐ Metadate ☐ Methamphetamine ☐ Ritalin ☐ Straterra ☐ Vyyanse ☐ Other (Please Specify):	☐ DMT ☐ Ecstasy ☐ Ketamine ☐ LSD ☐ Marijuana ☐ PCP ☐ Peyote ☐ Psilocybin (Mushrooms) ☐ Other (Please Specify):
Amount:	Amount:	Amount:	Amount:	Amount:	Amount:
Route:	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 First Use:
Date of Last 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: