

Behavioral Health Concurrent Review Form for Inpatient, Residential Treatment Center, Partial Hospital Program and Intensive Outpatient Program

Please submit your request electronically using our preferred method at <https://www.availity.com>.
If you prefer to fax this form, send to 844-445-6648.

Today's date:		
Contact information:		
Level of care:		
<input type="checkbox"/> Inpatient psych <input type="checkbox"/> Inpatient detox <input type="checkbox"/> Inpatient substance abuse rehab <input type="checkbox"/> PHP mental health <input type="checkbox"/> Psychiatric RTC <input type="checkbox"/> IOP mental health <input type="checkbox"/> IOP substance use <input type="checkbox"/> PHP substance use <input type="checkbox"/> Substance abuse RTC (ASAM level, if appropriate: _____)		
Member name:	Member ID or reference number:	Member DOB:
Member address:		Member phone number:
Facility account number:	For child/adolescent, name of parent/guardian:	Primary spoken language:
Name of utilization review (UR) contact:		UR phone number:
Admit date:		UR fax number:
<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary If involuntary, date of commitment:		
Admitting facility name:		Facility provider number or NPI:
Attending physician (first and last names):		Attending physician phone number:
Provider number or NPI:	Facility unit:	Facility phone number:
Discharge planner name:		Discharge planner phone number:
Diagnoses (psychiatric, chemical dependency and medical)		

* Availity, LLC is an independent company providing administrative support services on behalf of Dell Children's Health Plan.

Risk of harm to self (within last 24–48 hours)	Risk rating (check all that apply)
If present, describe: If prior attempt, date and description:	<input type="checkbox"/> Not present <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Prior attempt
Risk of harm to others (within last 24–48 hours)	Risk rating (check all that apply)
If present, describe: If prior attempt, date and description:	<input type="checkbox"/> Not present <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Prior attempt
Psychosis (within last 24–48 hours) Risk rating: (0 = None; 1 = Mild or Mildly Incapacitating; 2 = Moderate or Moderately Incapacitating; 3 = Severe or Severely Incapacitating; N/A = Not Assessed)	Symptoms (check all that apply)
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A If present, describe:	<input type="checkbox"/> Auditory/visual hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Delusions <input type="checkbox"/> Command hallucinations
Substance use Risk rating: (0 = None; 1 = Mild or Mildly Incapacitating; 2 = Moderate or Moderately Incapacitating; 3 = Severe or Severely Incapacitating; N/A = Not Assessed)	Substance (check all that apply)
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A If present, describe last use, frequency, duration, sober history:	<input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> PCP <input type="checkbox"/> LSD <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Opioids <input type="checkbox"/> Barbiturates <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Other (describe):
Urine drug screen?	Result (if applicable)
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive (If checked, list drugs): <input type="checkbox"/> Negative <input type="checkbox"/> Pending

For substance use disorders, please complete the following additional information, based on current assessment:

Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (describe or give symptoms)	Risk rating
Dimension 1 (acute intoxication and/or withdrawal potential such as vitals, withdrawal symptoms)	<input type="checkbox"/> Minimal/none — not under influence, minimal withdrawal potential <input type="checkbox"/> Mild — recent use but minimal withdrawal potential <input type="checkbox"/> Moderate — recent use, needs 24-hour monitoring <input type="checkbox"/> Significant — potential for or history of severe withdrawal, history of withdrawal seizures <input type="checkbox"/> Severe — presents with severe withdrawal, current withdrawal seizures
Dimension 2 (biomedical conditions and complications)	<input type="checkbox"/> Minimal/none — none or insignificant medical problems <input type="checkbox"/> Mild — mild medical problems that do not require special monitoring <input type="checkbox"/> Moderate — medical condition requires monitoring but not intensive treatment <input type="checkbox"/> Significant — medical condition has a significant impact on treatment and requires 24-hour monitoring <input type="checkbox"/> Severe — medical condition requires intensive 24-hour medical management
Dimension 3 (emotional, behavioral or cognitive complications)	<input type="checkbox"/> Minimal/none — none or insignificant psychiatric or behavioral symptoms <input type="checkbox"/> Mild — psychiatric or behavioral symptoms have minimal impact on treatment <input type="checkbox"/> Moderate — impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADLs <input type="checkbox"/> Significant — suicidal/homicidal ideations, behavioral or cognitive problems or psychotic symptoms require 24-hour monitoring <input type="checkbox"/> Severe — active suicidal/homicidal ideations and plans, acute psychosis, severe emotional lability or delusions; unable to attend to ADLs; psychiatric and/or behavioral symptoms require 24-hour medical management
Dimension 4 (readiness to change)	<input type="checkbox"/> Maintenance — engaged in treatment <input type="checkbox"/> Action — committed to treatment and modifying behavior and surroundings <input type="checkbox"/> Preparation — planning to take action and is making adjustments to change behavior, has not resolved ambivalence <input type="checkbox"/> Contemplative — ambivalent, acknowledges having a problem and beginning to think about it, has indefinite plan to change <input type="checkbox"/> Pre-contemplative — in treatment due to external pressure, resistant to change

Dimension 5 (relapse, continued use or continued problem potential)	<input type="checkbox"/> Minimal/none — little likelihood of relapse <input type="checkbox"/> Mild — recognizes triggers, uses coping skills <input type="checkbox"/> Moderate — aware of potential triggers for MH/SA issues but requires close monitoring <input type="checkbox"/> Significant — not aware of potential triggers for MH/SA issues, continues to use/relapse despite treatment <input type="checkbox"/> Severe — unable to control use without 24-hour monitoring, unable to recognize potential triggers for MH/SA despite consequences																		
Dimension 6 (recovery living environment)	<input type="checkbox"/> Minimal/none — supportive environment <input type="checkbox"/> Mild — environmental support adequate but inconsistent <input type="checkbox"/> Moderate — moderately supportive environment for MH/SA issues <input type="checkbox"/> Significant — lack of support in environment or environment supports substance use <input type="checkbox"/> Severe — environment does not support recovery or mental health efforts; resides with an emotionally/physically abuse individual or active user; coping skills and recovery require a 24-hour setting																		
Current treatment plan																			
Medications																			
Have medications changed (type, dose and/or frequency) since admission? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give medication, current amount and change date: Have any PRN medications been administered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give medication, administration date and current amount:																			
Member's participation in and response to treatment																			
Attending groups?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																		
Family or other supports involved in treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																		
Adherent to medications as ordered?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																		
Member is improving in (check all that apply): <table border="0" style="width: 100%;"> <tr> <td style="width: 20%;">Affect</td> <td style="width: 10%;"><input type="checkbox"/> Yes</td> <td style="width: 10%;"><input type="checkbox"/> No</td> <td style="width: 20%;">Thought processes</td> <td style="width: 10%;"><input type="checkbox"/> Yes</td> <td style="width: 10%;"><input type="checkbox"/> No</td> </tr> <tr> <td>Mood</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Performing ADLs</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Sleep</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Impulse control/behavior</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table>		Affect	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thought processes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mood	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Performing ADLs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Impulse control/behavior	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Support system Include coordination activities with case managers, family, community agencies and so on. If case is open with another agency, name the agency, phone number and case number.	
Discharge plan Note changes and barriers to discharge planning in these areas and plan for resolving barriers. If a recent readmission, indicate what is different about the plan from last time.	
Housing issues:	
Psychiatry:	
Therapy and/or counseling:	
Medical:	
Wraparound services:	
Substance use services:	
Planned discharge level of care:	
Expected discharge date:	
Submitted by:	Phone number: