Minuteman Health℠

FAMILY STABILIZATION INITIAL REVIEW FORM

BEHAVIORAL HEALTH DEPARTMENT
PHONE: 855-644-1776 FAX: 413.233.2700

Please complete thoroughly. Send completed form to Minuteman Health, Inc. (MHI) Behavioral Health Department for review and decision.

MUST ENCLOSE RELEVANT CLINICAL DOCUMENTATION TO SUPPORT THIS REQUEST.

Provider Name: _____ Office Phone: _____
Clinician Name: _____ Phone(s): _____
Member Name: _____ DOB: _____
MHI ID: _____
Date of Intake Appointment: _____ Referred by: _____

Diagnosis: Axis I: _____ _____ _____ _____
Axis II: _____ _____ _____
Axis III: _____
Axis IV: _____
Axis V: _____

Legal Guardian: _____ Physical Custodian: _____

Living situation/family system (e.g. family members, parents/caregivers, other non-family members in house): _____
_____
_____
_____
_____

Agency Involvement: ❑ DMH ❑ DMR ❑ DCF ❑ DYS ❑ Probation
Therapist Name: _____ Psychiatrist Name: _____
School: _____ Grade: _____
Is child receiving special education services?: ❑ Yes ❑ No If yes, is IEP in place? ❑ Yes ❑ No
Other important people involved in the member's and family's life: _____
Medications: _____

INITIAL TREATMENT PLAN

Problem Area #1: _____
_____
_____
_____
Treatment Goals: _____
_____
_____
_____
Treatment Interventions: _____
_____
_____

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FAMILY STABILIZATION TEAM INITIAL REVIEW FORM (PAGE 2)

Problem Area #2: _____

_____

_____

_____

Treatment Goals: _____

_____

_____

_____

Treatment Interventions: _____

_____

_____

Problem Area #3: _____

_____

_____

_____

Treatment Goals: _____

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_____

Treatment Interventions: _____

_____

_____

Problem Area #4: _____

_____

_____

_____

Treatment Goals: _____

_____

_____

_____

Treatment Interventions: _____

_____

_____

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