Minuteman Health™

INPATIENT DETOXIFICATION CLINICAL REVIEW FORM (PAGE 1)

- ☐ INPATIENT DETOXIFICATION
- ☐ INPATIENT REHABILITATION
- ☐ DUAL DIAGNOSIS ACUTE RESIDENTIAL TREATMENT (DD-ART)

FAX: 413.233.2800

The following information is required for reviews. Please complete thoroughly. If any of these questions are not applicable, please indicate.

INITIAL CLINICAL REVIEW

Facility Name:________________ Phone: ________________

Attending Provider Name:________________ Phone: ________________

Utilization Review Contact:________________ Phone:________ Fax:________

Member Name:________________ Date of Birth:________________

MHI Member ID#:________________ Today's Date: ________________

Level of Care: ☐ Inpatient Detoxification ☐ Inpatient Rehabilitation ☐ Dual Diagnosis Acute Residential Treatment (DD-ART)

1. Date of Admission:________ 2. Date of Intake Appointment:________ 3. Referral Source: ________
4. Diagnoses I-V:

   Axis I: ________ ________ ________

   Axis II:________________

   Axis III: ________ ________ ________ ________

   Axis IV: (Describe) ________________

   Axis V: (Current)________________ Highest in Past Year ________________

5. Precipitating Reason for Admission:
6. CIWA or COWS Score:________ Signs and Symptoms for Which Member is Scoring: ________________
7. Vitals: BP________ Pulse________ Respiration________ Temp ________
8. Current Treatment Plan Including Detox Protocol, and Type and Amount of Medication Given to Date: ________________
9. Treatment History/Prior Admissions: ________________
10. Identify Which Risks are Currently Present and How the Risk is Being Addressed:

    ☐ History of DTs or Grand Mal Seizures (Specify with Dates): ________________

    ☐ Suicidal/Homicidal:________________

    ☐ Severe Functional Impairments/Jeopardies:________________

    ☐ Other:

11. Substances Used and for Which Detoxification is Required (Specify Amount, Frequency and Duration of Use): ________________
12. Psychiatric Medications: ________________
13. Date Family Meeting Scheduled: ________________
14. Current Outpatient Providers: ________________

    14 a. Has this Provider Been Notified of Member's Admission? ☐ Yes ☐ No If No, When Will This Occur? ________

15. Any Other Clinical Information to Consider (Attach Additional Pages if Necessary): ________________

(CONTINUES ON NEXT PAGE)

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INPATIENT DETOXIFICATION CLINICAL REVIEW FORM (PAGE 2)

- ■ INPATIENT DETOXIFICATION
- ■ INPATIENT REHABILITATION
- ■ DUAL DIAGNOSIS ACUTE RESIDENTIAL TREATMENT (DD-ART)

FAX: 413.233.2800

Member Name:____________________________Date of Birth:________________________MHI Member ID#: __________________________

16. Discharge Plan: ____________________________________
17. Anticipated Discharge Date: ______________________________

CONCURRENT REVIEW

1. If Any Change in Diagnosis, Please Identify and Comment: ________________________
2. Identify Which Risks are Currently Present and How the Risk is Being Addressed:
   - ☐ History of DTs or Grand Mal Seizures (Specify With Dates): ____________________
   - ☐ Suicidal/Homicidal:________________________________
   - ☐ Severe Functional Impairments/Jeopardies: ________________________
   - ☐ Other: ____________________________________
3. CIWA or COWS Score:____________Signs and Symptoms for Which Member is Scoring:________________________

   ____
4. Vitals: BP__________________ Pulse__________________ Respiration__________________ Temp ________________
5. Current Treatment Plan Including Detox Protocol, and Type and Amount of Medications Given During Review Period: ________________

   ____
6. Date Family Meeting Scheduled: ______________________________
7. Current Psychiatric Medications: ______________________________
8. Any Other Clinical Information to Consider (Attach Additional Pages if Necessary): ________________________
9. Discharge Plan: ____________________________________
10. Anticipated Discharge Date: ______________________________

DISCHARGE REVIEW

1. Discharge Date:________________Type: ☐ Regular ☐ Admin ☐ AMA ☐ ACA
2. Discharge Diagnoses I-V:

   Axis I: ________________________ ________________________ ________________________

   Axis II: ________________________ ________________________ ________________________

   Axis III: ________________________ ________________________ ________________________

   Axis IV: (Describe) ____________________________________

   Axis V: (Current)______________________________Highest in Past Year ____________________
3. Level of Care after Discharge (Check one): ☐ Rehab ☐ PHP ☐ IOP Facility name:________________________Start Date: ____________

   ☐ OP, then: Therapist's Name____ Date/Time:________________________

   Psychiatrist's or Med Provider's Name: ______________________________ Date/Time:
4. Discharge Psychiatric Medications and Dosages: ______________________________
5. Involvement/Role of Family and/or Significant Other in Aftercare Plan:________________________
6. Member's Contact Info: Home Phone: Cell Phone: ________________________
7. Is a Member Having Any Barriers to Follow-Up Care (e.g. Transportation, Financial, Language, Finding a Provider, etc.)?

   ☐ Yes ☐ No If Yes, Please Describe: ____________________________________

   (Note: Please contact MHI 855.644.1776, If You Need Assistance with Helping Member Find An In-Plan Provider.)