- INPATIENT PSYCHIATRIC
- ACUTE RESIDENTIAL TREATMENT (ART)
- CRISIS STABILIZATION UNIT (CSU)

HEALTH SERVICES DEPARTMENT
FAX: 413.233.2700

The following information is required for reviews. Please complete it thoroughly. If any of these questions are not applicable, please indicate that. Fax the completed form to the Minuteman Health, Inc. (MHI) Behavioral Health Department at 413.233.2700.

INITIAL CLINICAL REVIEW

Facility Name: ______________________________ **Phone:** ______________

Attending Provider (MD) Name: ______________________ **Phone:** ______________

Utilization Review Contact: ______________________ **Phone:** ________ **Fax:** ______

Member Name: ______________________________ **Date of Birth:** ____________

MHI Member ID#: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Today's Date:** ____________

Level of Care: □ Inpatient □ ART □ CSU

1. Date of admission: ____________
2. Evaluated by crisis team : □ Yes □ No Which team or other referral source: ____________
3. Legal status: □ Section 12 □ Section 35 □ Conditional Voluntary
4. Diagnoses I-V:

   Axis I: ____________ ____________ ____________ ____________

   Axis II: ____________ ____________ ____________ ____________

   Axis III: ____________ ____________ ____________ ____________

   Axis IV: (Describe) ______________________________

   Axis V: Current ______________ Highest in past Year ______________
5. Acute symptoms / Behavior requiring admission: ______________________________

   ____
6. Treatment history/ Prior admissions: ______________________________
7. Identify and provide details about risks currently present:

   □ Suicidal ______________________________

   □ Homicidal ______________________________

   □ Severe functional impairments ______________________________

   □ Other ______________________________
8. Current treatment plan: ______________________________

   ____
9. Current psychiatric medications: ______________________________

   ____
10. If the member is non-compliant with medications when indicated or is otherwise non-compliant with treatment, what is the plan to address the issues? ______________________________
11. Any other clinical information to consider (attach additional pages if necessary): ____________
12. Information about active substance abuse and withdrawal medications administered: ____________

    ____
13. Date family meeting scheduled: ______________________________
14. Current outpatient provider(s): ______________________________

    a.) Has this provider been notified of member's admission? □ Yes □ No b.) If no, when will this occur? ______

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HEALTH SERVICES DEPARTMENT
FAX: 413.233.2700

Member Name: ____________________________ **Date of Birth:** _____________ **MHI Member ID#:** ____________________

15. Discharge Plan: ____
16. Anticipated discharge date: ____

CONCURRENT REVIEW Check one: ☐ IP ☐ ART ☐ CSU

1. If any change in diagnosis or condition, please identify and comment: ____
____
2. Provide details about acute risk factors as manifested by member's mental status and behaviors since the last review:
   - ☐ Suicidal ____
   - ☐ Homicidal ____
   - ☐ Severe functional impairments ____________________________
   - ☐ Other ____
3. Current treatment plan: ____
4. Date family meeting scheduled: __________________________________
5. Current psychiatric medications: ___________________________________
6. If member is refusing medications, what is being done to ensure medications are being given? _________________
____
7. Any other clinical information to consider (attach additional pages if necessary): __________________________
____
8. Discharge plan: ____
9. Anticipated discharge date: __________________

DISCHARGE REVIEW Check one: ☐ IP ☐ ART ☐ CSU

1. Discharge date: ______________
2. Discharge diagnoses I-V:
   - Axis I: ____
   - Axis II: ____
   - Axis III: ____
   - Axis IV: (Describe) ________________________________
   - Axis V: Current ____________________________________
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 medical 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/Guardian's contact info: Home #: ____________________ Cell #: ______________________
7. Is member having any barriers to follow-up care (ex: transportation, financial, language, finding a provider, etc.)?
____

(Note: Please contact MHI at 855-644-1776, for help finding an in-plan provider for the member.)

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