Minuteman Health[SM]

INTENSIVE OUTPATIENT PROGRAM CLINICAL REVIEW FORM

BEHAVIORAL HEALTH DEPARTMENT
FAX: 413.233.2700

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

1. Date of Admission: _________ Date of Intake Appointment: _________ Referral Source: __________
2. Number of days requested: ___________ Requested review date: ____________
3. Diagnoses I-V:
   - Axis I: ______________________ ______________________ ______________________
   - Axis II: ______________________ ______________________ ______________________
   - Axis III: ______________________ ______________________ ______________________
   - Axis IV: (Describe) ____
   - Axis V: Current _________________ Highest in Past Year _________________
4. Reason for seeking treatment including pattern and extent of recent substance abuse: ________________________
   ____
5. Third party mandated: ☐ No ☐ Yes By whom: ____
6. Treatment history/prior admissions: ____
7. Identify and provide details about risks currently present:
   - ☐ Cravings to use ____
   - ☐ Suicidal / Homicidal ____
   - ☐ Severe functional impairments / Jeopardies ____
8. Current Treatment Plan: ____
   ____
9. Current 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. Date Family Meeting Scheduled: ____
12. Current Outpatient Providers: ____
13. Any other clinical information to consider (attach additional pages if necessary): ___________________________
    ____
14. Plan to address active substance abuse: ____

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Member Name: ______________________________ **Date of Birth:** ________________ **MHI Member ID#:** ______________

15. Discharge Plan: ____

16. Anticipated Discharge Date: ____

CONCURRENT REVIEW

1. Number of days used since last review: ____________________ Number of additional days requested: ___________
2. If days missed, why? ___________________________ Excused? ☐ Yes ☐ No
3. If any change in Diagnosis, please identify and comment: ____
____
4. Identify which risks are currently present and how the risk is being addressed (specify any incidents or relapse since start of program): ____
   - ☐ Cravings to use ____
   - ☐ Suicidal / Homicidal ____
   - ☐ Severe functional impairments / Jeopardies ____
5. Current Treatment Plan: ____
6. Date Family Meeting Scheduled: ____
7. Contacts with and recommendations of the outpatient providers: ____
8. Current Psychiatric Medications: ____
9. Any other clinical information to consider (attach additional pages if necessary): ____________________________
____
10. Discharge Plan: ____
____
11. Anticipated Discharge Date: ____

DISCHARGE REVIEW

1. Date of last attendance: ________ Number of days used: _______ Type of discharge: ☐ Regular ☐ Admin ☐ AMA
2. Discharge Diagnoses I-V:
   - Axis I: ________________________ ________________________ ________________________
   - Axis II: ________________________ ________________________ ________________________
   - Axis III: ________________________
   - Axis IV: ________________________
   - Axis V: Current ____________________ Highest in Past Year ________________________
3. Discharge Medications and Dosages: ____
4. Level of Care after Discharge: ____
5. Names of providers for aftercare: ____
6. Dates of appointments with aftercare providers: ____
7. Involvement/role of family and/or significant other in aftercare plan: ______________________________
____

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