Minuteman Health™

MENTAL HEALTH INTERMEDIATE CARE

■ PARTIAL HOSPITAL PROGRAM ■ DAY TREATMENT
INTENSIVE OUTPATIENT PROGRAM

Fax: 413-233-2700

☐ PARTIAL HOSPITAL PROGRAM ☐ INTENSIVE OUTPATIENT PROGRAM

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 MHI Behavioral Health Department at 413-233-2800.

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: _____
5. Treatment history/prior admissions: _____
6. Identify and provide details about risks currently present:
   - ☐ Suicidal _____
   - ☐ Homicidal _____
   - ☐ Severe functional impairments _____
   - ☐ Other _____
7. Current Treatment Plan: _____

   _____
8. Current Psychiatric Medications: _____
9. 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? _____
10. Any other clinical information to consider (attach additional pages if necessary): _____

    _____
11. If applicable, information about active substance abuse: _____

    _____
12. Date Family Meeting Scheduled: _____
13. Current Outpatient Providers: _____

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RTIAL HOSPITAL PROGRAM Y TREATMENT
ENSIVE OUTPATIENT PROGRAM

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Member Name:_____ Date of Birth: _____MHI Member ID#:_____

14. Discharge Plan: _____
15. 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 they are being addressed (specify any incidents since start of program): _____

   _____

   ☐ Suicidal _____

   ☐ Homicidal _____

   ☐ Severe functional impairments

   ☐ Other _____
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. Last date of 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 Psychiatric 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:_____