Minuteman Health™

SUBSTANCE ABUSE INTERMEDIATE CARE

- PARTIAL HOSPITAL PROGRAM
- INTENSIVE OUTPATIENT PROGRAM

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 MHI Behavioral Health Department at (413) 233-2800.

INITIAL CLINICAL REVIEW

Facility Name: _____ **Phone:** _____

Address: _____ **NPI#:** _____

Attending Provider (MD) Name: _____ **Phone:** _____

Utilization Review Contact: _____ **Phone:** _____ **Fax:** _____

Member Name: _____ **Date of Birth:** _____

Minuteman Health 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 use: _____

   _____
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:**_____ **Health New England 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 relapses since start of program):

_____

☐ Craving to use _____

☐ Suicidal / Homicidal_____

☐ Severe functional impairments_____

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:_____

_____