

**CARE MANAGEMENT INPATIENT LOC INITIAL/CONCURRENT REVIEW DECISION SUPPORT TOOL**

UR PHONE: \_\_\_\_\_ UR FAX: \_\_\_\_\_ UR EMAIL: \_\_\_\_\_

|                        |                                                                                                     |                                                                                                                                  |
|------------------------|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| <b>Date of Review:</b> | <input type="checkbox"/> <b>Initial Review</b><br><input type="checkbox"/> <b>Concurrent Review</b> | <input type="checkbox"/> <b>Voluntary</b> <input type="checkbox"/> <b>Involuntary</b><br><small>NA, Patient is Voluntary</small> |
| <b>Date of Admit:</b>  | <b>Info provided by:</b>                                                                            | <b>Attending MD:</b>                                                                                                             |
| <b>Member Name:</b>    |                                                                                                     | <b>Medicaid #:</b>                                                                                                               |
| <b>Facility:</b>       |                                                                                                     | <b>Additional days requested:</b>                                                                                                |

Current Condition (e.g. PRN medications needed; level of observation; use of restraints/seclusion; group participation; assaultive/destructive behaviors; suicidal/homicidal ideation; medication effectiveness; significant lab reports/therapeutic blood levels; appetite disturbance; sleep disturbance; need for medication evaluation; abnormal vital signs; progress toward treatment goals):

Certification criteria based on current condition (check all that apply):

- ☐ Evidence of behavioral health diagnosis    
 ☐ Lower level of care not appropriate    
 ☐ Danger to self/others  
☐ Likely to suffer neglect/refuse to care for self    
 ☐ Treatment interventions not exhausted  
☐ Need for continued intervention to work toward completion of treatment goals

**Diagnoses (List All):**

- ☐ See H and P included with submission    
 ☐ Change in Diagnosis since last review    
 ☐ No change in Diagnosis since last review

**Current Medications as of today:** ☐ No medication changes since last review (N = New medication C = Changed dose)

| Medication                                               | Dose Information | Date Began | Comments: |
|----------------------------------------------------------|------------------|------------|-----------|
| <input type="checkbox"/> N<br><input type="checkbox"/> C |                  |            |           |
| <input type="checkbox"/> N<br><input type="checkbox"/> C |                  |            |           |
| <input type="checkbox"/> N<br><input type="checkbox"/> C |                  |            |           |
| <input type="checkbox"/> N<br><input type="checkbox"/> C |                  |            |           |
| <input type="checkbox"/> N<br><input type="checkbox"/> C |                  |            |           |
| <input type="checkbox"/> N<br><input type="checkbox"/> C |                  |            |           |
| <input type="checkbox"/> N<br><input type="checkbox"/> C |                  |            |           |
| <input type="checkbox"/> N<br><input type="checkbox"/> C |                  |            |           |
| <input type="checkbox"/> N<br><input type="checkbox"/> C |                  |            |           |

☐ **Meds discontinued since last review:** \_\_\_\_\_

**Discharge Plan:** ☐ Unable to determine at time of review   ☐ Home with out-patient follow-up

☐ An alternative level of care is anticipated upon discharge: \_\_\_\_\_

☐ Obstacles to discharge: \_\_\_\_\_

**Family or S/O involved:** ☐ Yes   ☐ No \_\_\_\_\_

Please attach clinical documentation to include: Member Face Sheet, any clinical assessments that would tell us why the member was admitted and/or continues to require this level of care, and a copy of the Baker Act (if available).