western sky community care™
5300 Homestead Rd NE
Albuquerque, NM 87110

Behavioral Health
Initial Clinical Review Form

(Address all areas. An incomplete form may result in a delay of your request.)

Submit completed form to:

Online: Provider Portal

Fax: 844-618-9572

Date Form Completed:

Facility Information

Name of Facility:

Out of State Facility: YES ◯ NO ◯ National Provider ID:
If Yes: Must attach denial letters from in state facilities

Address/Service Location:

Facility/Program Contact:
(Name)

Phone: Fax: Date of Admission:

Level of Care Requested:
(include Billing Code)

Requested Dates of Service: Requested Number of Service Units:

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Facility Information

Is member currently in detention? YES ◯ NO ◯
(If Yes: 1 day business TAT required for RTC LOC requests.)

If Yes, Name of location:

Is member involved with CYFD Juveniles Justice Services (JJS)? YES ◯ NO ◯

If Yes, JJS Staff Person Name: Phone:

Additional Comments/Notes:

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Member Information

Member Name:
(First/Last)

Member ID or SSN: Member DOB: Member Age:

Name of Legal Guardian:

Guardian Address: Phone:

Consumer's currently lives with:
(homeless, parents/siblings)

Is the member involved with CYFD-CPS? YES ◯ NO ◯

Is the member currently in custody of CYFD? YES ◯ NO ◯

If Yes, CYFD SW Name: Phone:

Is the member involved with Adult Protective Services? YES ◯ NO ◯

If Yes, APS SW Name: Phone:

Is member involved with CYFD Juveniles Justice Services (JJS)? YES ◯ NO ◯

If Yes, JJS Name: Phone:

Power of Attorney (POA) Name: Phone:

Treatment Guardian Name: Phone:

DD Waiver Status:

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DSM Diagnoses

DSM Diagnosis:
(Include DSM codes)

Description of Medical Needs:
(Including DME and chronic/co-morbid conditions)

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Participant for Treatment/Admission

Has parent/guardian agreed to participate in Treatment Planning and Therapy Sessions? YES ◯ NO ◯

If No, why not?

Is the member medically stable? YES ◯ NO ◯

Member referred to this facility by:

Precipitant for Request

(Describe current behaviors that justify LOC.)

Interventions in the past year that have been unsuccessful and led to the need for LOC:
(Treatment History)

Most Recent MH/SA Provider:

Is the member active in a CSA? YES ◯ NO ◯

If No, why not?

History of Out-of-Home Placements:

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Precipitant for Request

Family/Guardian and/or Primary Support in the past year:
(including participation in lower LOC treatment, if parent/guardian has not been involved please give reason)

Family History of Mental Health issues:

Additional Comments/Notes:

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Current Functioning in Other Domains

Describe Current Functioning in Other Domains:
(school program, attendance, participation in outpatient therapy including adherence to medications, leisure activities)

Language/Spiritual/Cultural Factors:
(How will these affect treatment engagement? Be sure to incorporate into treatment plans.)

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Mental Status Exam

MSE was completed by:
(Name)

Date Completed:

If not completed, why not?

Appearance and Behavior:
(posture, gestures, attire, facial expressions and speech)

Attention:
(normal, alter, impaired)

Mood:
(normal, euphoric, agitated, sad, etc.)

Affect:
(appropriate, inappropriate, flat, etc.)

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Perception:
(hallucinations, delusions, etc.)

Thought Content/Process:
(logical, de-realizations, SI/HI, etc.)

Orientations:
(time, person, place, circumstances)

Insight:
(good/fair/poor/absent)

Activities of Daily Living:
(i.e. within normal limits, impaired)

Sleep:
(e.g. disturbed, early morning awakening, etc.)

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Risk Assessment

Does the member currently have suicidal or homicidal ideation? YES ◯ NO ◯

Means:

Motives:

Plan/Intent:

Current aggression that justifies LOC:

Active psychosis:
(describe)

Other dangerous or self-injurious behaviors:

Does the member have a current/history of substance abuse? YES ◯ NO ◯

SA Frequency/Duration: SA Last use:

Is there any known history of substance use by family members? YES ◯ NO ◯

Does the member have a history of domestic violence? YES ◯ NO ◯
(witness or harm to/by family members)

Does the member have access to guns in the home? YES ◯ NO ◯

Is the member willing/able to contract for safety? YES ◯ NO ◯

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Current Medications

(List all MH/SA and Medical)

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

Name:

Dose: Frequency Taken: Date Started:

Prescriber:

Is member adherent to medication? YES ◯ NO ◯

If No, why not

Response to medication:

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Initial Treatment Plan

Summary of Treatment Plan:
(What are the identified problem areas that will be a focus of treatment?)

Other factors/pertinent information impacting treatment:

Discharge Plan

Current ELOS:
(estimated length of stay)

What is the preliminary discharge plan?

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