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

# Behavioral Health
# Concurrent 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**

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**Date Form Completed:**

## Facility Information

Name of Facility:

Out of State Facility (Y/N):

National Provider ID:

Address/Service Location:

Facility/Program Contact (Name):

Phone:

Fax:

Level of Care Requested (include Billing Code):

Date of Admission:

Requested Dates of Service:

Requested Number of Service Units:

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## Member Information

Member Name (First/Last):

Member ID or SSN:

Member DOB:

Member Age:

Name of Legal Guardian:

Guardian Address:

Guardian 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?

If Yes, APS SW Name/Phone:

Is member involved with CYFD Juveniles Justice Services (JJS) (Y/N)?

If Yes, JJS Name/ Phone:

Power of Attorney (POA) Name/Phone:

Treatment Guardian Name/Phone:

DD Waiver Status:

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## DSM Diagnoses Upon Discharge

DSM Diagnosis (Include DSM codes):

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

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## Reason for Concurrent Request

Summary of current symptoms, behaviors and reason to continue at this level of care (specify intensity, frequency and duration):

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Describe consumer's response to treatment (include responses to psychotherapy, milieu interventions, etc.):

Has parent/guardian participated in Treatment Planning and Therapy Sessions (Yes/No)?

If No, why not?

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List individual/family therapy sessions since last review:

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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.):

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?

Means:

Motives:

Plan/Intent:

Current aggression that justifies LOC:

Active psychosis (describe):

Other dangerous or self-injurious behaviors:

Does the member have a current substance abuse?

SA Frequency/Duration:

SA Last use:

Is the member willing/able to contract for safety?

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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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(List all MH/SA and Medical)

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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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## Treatment Plan

Summary of Treatment Plan (Include Long Term Goals, Short Term Objectives and interventions with timeframes that focus on identified problem areas in current clinical presentation documented above.)

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Other factors/pertinent information impacting treatment:

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## Discharge Plan

Current ELOS (estimated length of stay):

Where will member live upon discharge and what LOC is preliminarily recommended?

What resources or providers in the member's community were identified?

Has parent/guardian agreed to the preliminary discharge plan (Yes/No)?

If No, why not?

Discharge Planner Name/Number:

Has MCO Care Coordinator been involved with discharge planning?