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**

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:

DSM Diagnosis

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):

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?

Therapist Name/Phone:

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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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.)

Other factors/pertinent information impacting treatment:

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?