

BCN Behavioral Health Inpatient Concurrent Review Form

Review date:		Member name:			Member ID #:				
Diagnosis:		Provider NPI:		Provider tax ID:		DSM-IV code:			
Provider name:						Telephone #:			
Therapist name:					Reviewer name:				
Date(s) of service:									
PCP name:				PCP release:	<input type="checkbox"/> Offered / signed		Date:		
Date PCP communication occurred:					<input type="checkbox"/> Offered / declined		Date:		

Problems, symptoms, need for continued care
Presenting problem (include precipitant to admission):
Current symptoms (include list of specific symptoms in the last 24 hours):
Baseline functioning (describe patient's typical functioning prior to onset of symptoms):
Justification for continued stay (include reason patient continues to need this level of care):

Barriers to discharge (please circle whether barrier is an issue / is not an issue and document plan to address).	
Housing	Check one: <input type="checkbox"/> issue / <input type="checkbox"/> not an issue Plan to address:
Poor supports	Check one: <input type="checkbox"/> issue / <input type="checkbox"/> not an issue Plan to address:
Lack of family involvement	Check one: <input type="checkbox"/> issue / <input type="checkbox"/> not an issue Plan to address:
Noncompliance with treatment	Check one: <input type="checkbox"/> issue / <input type="checkbox"/> not an issue Plan to address:

Barriers to discharge continued (please circle whether barrier is an issue / is not an issue and document plan to address).	
Job jeopardy	Check one: <input type="checkbox"/> issue / <input type="checkbox"/> not an issue
	Plan to address:
Safety plan	Check one: <input type="checkbox"/> issue / <input type="checkbox"/> not an issue
	Plan to address:
Transportation issues	Check one: <input type="checkbox"/> issue / <input type="checkbox"/> not an issue
	Plan to address:
Other: _____	Check one: <input type="checkbox"/> issue / <input type="checkbox"/> not an issue
	Plan to address:

Goals of treatment for this level of care (include list of active interventions that will address the reason for admission, current symptoms, and problems).	
Goal 1	Statement of goal:
	Plan for achieving goal:
	Progress:
Goal 2	Statement of goal:
	Plan for achieving goal:
	Progress:
Goal 3	Statement of goal:
	Plan for achieving goal:
	Progress:
Goal 4	Statement of goal:
	Plan for achieving goal:
	Progress:
Medication(s): (include dosages/changes)	
Additional days requested for current level of care:	

Discharge information					
Discharge plan:				Anticipated discharge date:	
Follow-up appointments:	<i>Provider type</i>	<i>Name</i>	<i>Telephone #</i>	<i>Date</i>	<i>Time</i>
	Therapist/Program:				
	Psychiatrist:				