BEHAVIORAL HEALTH
INITIAL CLINICAL REVIEW FORM

(Please address each area. An incomplete form may result in a delay of your request.)

Submit completed form to:

Email: BHRequests@Molinahealthcare.com

Fax: 505.924.8237 or 888.295.5494

Date Form Completed:

FACILITY INFORMATION

Name of Facility:

Out of State Facility (Y/N):

If Yes: Must attach denial letters from in state facilities.

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:

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) (Y/N)?

If Yes, JJS Staff Person Name/ Phone Number:

MEMBER INFORMATION

**Please complete applicable fields.*

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 DIAGNOSES

Admitting DSM Diagnosis (Include DSM codes):

Historical DSM Diagnosis (Clarify what is the source of information.):

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

PRECIPITANT 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?

If yes, what CSA?

History of Out-of-Home Placements:

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:

DESCRIBE CURRENT FUNCTIONING IN OTHER LIFE DOMAINS (Including 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.):

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.):

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/history of substance abuse?

SA Frequency/Duration:

SA Last use:

Is there any known history of substance use by family members?

Does the member have a history of domestic violence (witness or harm to/by family members)?

Does the member have access to guns in the home?

Is the member willing/able to contract for safety?

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:

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?