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: YES NO National Provider ID:

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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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)

Additional Comments/Notes:

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Reason for Concurrent Request

Summary of current symptoms, behaviors and reason to continue at this level of care:
(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.)

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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 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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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)

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: Phone:

Has MCO Care Coordinator been involved with discharge planning? YES NO

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Additional Comments/Notes:

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