

**Member Demographics & Authorization Details**

Member name/Medicaid number:

Admission date:

Facility name/state:

**Concurrent Review****Authorization Details**

Last covered day:

Submission date:

Attending physician name, credentials:

UR name/phone and fax numbers:

**Clinical Information**

Updated diagnoses (BH, medical, comorbidities):

Current unit precautions:

Treatment plan, objectives, and update on progress (please attach most recent treatment plan/update):

Dates of passes completed in the previous review period:

Additional issues to be addressed in treatment:

MD/RN/therapy/staff notes (please be sure to include group therapy dates and individual therapy note(s) in last week, and family therapy note(s) since last review):

MD/RN/therapy/staff notes (please be sure to include group therapy dates and individual therapy note(s) in last week, and family therapy note(s) since last review):

### Substance Use History

Updates to substance use concerns:

### Medications

Current medications including PRNs (name, dosage, frequency, start date, end date):

Vitals (include height, weight, BMI):

**Labs Since Last Review**     **Yes**     **No**

If yes, please provide:

### Discharge Plan

Discharge planner name/phone number:

Discharge barriers:

Member's primary support:

Updated discharge plan (provide as much detail as possible including, planned DC location, and follow-up appointments):

### Additional Notes

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