Behavioral Health
Acute Continued Stay Review Form

arkansas total care

Member Name:		Date of Birth:
Facility:	NPI:	TIN:
UR Contact Name:	Phone:	Fax:
Attending Physician:	Credentials:	
Is Member in DHS Custody? ☐ Yes ☐ No		
Reason for Admission:		
Home Medications and Compliance:		
Psychiatric Diagnoses (please identify primary diagnosis):		
Precautions:		
MD Notes (day prior to last covered day and forward; please include dates)**:**		

RN Notes (day prior to last covered day and forward; please include dates):
Date of Family Session: If there has not been a family session, please explain and/or provide the future date at which one will be held.
Current Psychiatric Medications: Include medication names with dates and description of change (started, increased, or decreased).
PRNs and Chemical Restraints: Note the date and reason.

Vitals:	**Height:**	**Weight:**	**BMI:**

Lab Results:	
Discharge Planner Name:	**Phone Number:**
Member's Primary Supports and Potential Barriers to Discharge:	
Discharge Location and Follow-Up Mental Health Provider Appointments: If appointment is not yet solidified, please note the reason why.	