HNE
Health New England

One Monarch Place · Suite 1500
Springfield, MA 01144-1500
413.787.4000 · 800.842.4464 · hne.com

INPATIENT PSYCHIATRIC/ACUTE RESIDENTIAL TREATMENT (ART) CRISIS STABILIZATION UNIT (CSU) CLINICAL REVIEW FORM

BEHAVIORAL HEALTH DEPARTMENT
PHONE: (413) 787-4000, EXT. 5028 FAX: (413) 233-2800

The following information is required for reviews. Please complete thoroughly. If any of these questions are not applicable, please indicate. Once completed fax the form to the HNE Behavioral Health Department at 413-233-2800.

INITIAL CLINICAL REVIEW

Facility Name: _____ **Phone:** _____

Attending Provider (MD) Name: _____ **Phone:** _____

Utilization Review Contact: _____ **Phone:** _____ **Fax:** _____

Member Name: _____ **Date of Birth:** _____

HNE Member ID#: _____ **Today's Date:** _____

Level of Care: ☐ Inpatient ☐ Art ☐ CSU

ADMISSION REVIEW

1. Date of Admission: _____
2. Evaluated by crisis team: ☐ Yes ☐ No Which Team or Other Referral Source: _____
3. Legal Status: Section 12 ☐ Sect 35 ☐ or Conditional Voluntary ☐
4. Diagnosis I-V:
   - Axis I: _____ _____ _____
   - Axis II: _____ _____ _____
   - Axis III: _____
   - Axis IV: _____
   - Axis V: Current _____ Highest in Past Year _____
5. Precipitating reason for admission: _____
6. Treatment history/prior admissions: _____
7. Identify which risks are currently present and how the risk is being addressed:
   - ☐ Suicidal _____
   - ☐ Homicidal _____
   - ☐ Severe functional impairments _____
   - ☐ Other _____
8. Current Treatment Plan: _____
   _____
9. Current Psychiatric Medications: _____
10. If the member is non-compliant with medications when indicated or is otherwise non-compliant with treatment, what is the plan to address the issues? _____
11. Any other clinical information to consider (attach additional pages if necessary): _____
12. If applicable, information about active substance abuse/detoxifications: _____
    _____

(CONTINUES ON NEXT PAGE)

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Member Name:_____ **Date of Birth:** _____**HNE Member ID#:**_____

13. Date Family Meeting Scheduled: _____
14. Current outpatient providers: _____
15. Discharge Plan: _____
16. Anticipated Discharge Date: _____

CONCURRENT REVIEW

1. If any change in Diagnosis, please identify and comment: _____

   _____
2. Identify which risks are currently present and how the risk is being addressed:
   - ☐ Suicidal _____
   - ☐ Homicidal _____
   - ☐ Severe functional impairments _____
   - ☐ Other _____.
3. Current Treatment Plan: _____

   _____
4. Date Family Meeting Scheduled: _____
5. Current Psychiatric Medications: _____
6. If Member is refusing medications, what is being done to ensure medications are being given? _____

   _____
7. Any other clinical information to consider (attach additional pages if necessary): _____

   _____
8. Discharge Plan: _____
9. Anticipated Discharge Date: _____

DISCHARGE REVIEW

1. Discharge Diagnoses I-V:

   Axis I: _____ _____ _____

   Axis II: _____ _____ _____

   Axis III: _____

   Axis IV: _____

   Axis V: Current _____ Highest in Past Year _____
2. Discharge Psychiatric Medications and Dosages:_____
3. Level of Care after Discharge:_____
4. Name of providers for aftercare:_____
5. Dates of appointments with aftercare providers:_____
6. Involvement/role of family and/or significant other in aftercare plan:_____
7. Member's Contact Info: Home #: _____ Cell #: _____