Use for Admission ONLY

BHRP EXPRESS REVIEW Acute Care Treatment Review Form

Client Name (Last, First):_____
Medicaid ID# or Social Security Number:_____
Client's Date of Birth:_____ Admission Date:_____
Client's Address:_____
Provider Name: Natchaug Hospital
Provider Service Address: 189 Storrs Rd., Mansfield Center, CT 06250

SELECT LEVEL OF CARE: (must choose one)

- ☐ Acute Inpatient Mental Health (MH IV.2)
- ☐ Medically-Managed Inpatient Detoxification (SA IV.2)

LEGAL STATUS:

- ☐ Voluntary
- ☐ Involuntary/PEC

DIAGNOSES

Primary BH Diagnosis: _____
Secondary BH Diagnosis: _____
Medical Diagnosis (1): _____
Medical Diagnosis (2): _____

RISK ASSESSMENT

Risk (Required)	Risk Level (Required)
Self-Harm/Suicide:	☐ Absent ☐ Low ☐ Medium ☐ High
☐ Current SI w/plan/intent ☐ SI w/plan only ☐ Hx of past attempts ☐ SI not current	
Harm to others/Assaultiveness:	☐ Absent ☐ Low ☐ Medium ☐ High
☐ Current HI/assault w/plan/intent ☐ HI w/threats only ☐ Hx past attempts ☐ None currently	
Withdrawal complication potential:	☐ Absent ☐ Low ☐ Medium ☐ High
Grave Disability:	☐ Absent ☐ Low ☐ Medium ☐ High
Psychosis:	☐ Absent ☐ Low ☐ Medium ☐ High
☐ Paranoia ☐ Auditory Hallucinations ☐ Mania ☐ Thought disorder	
☐ Delusions ☐ Visual Hallucinations ☐ Inappropriate affect	

Projected Discharge Plan (Required):
Anticipated Discharge Date: _____
Referral Projected to: _____ (Service/Level of Care)
_____ (Provider Name)

Substance Use History (Required for all Detox & Co-Occurring Admissions):

Substance	Date Last Used	Method of Use	Age at First Use	Quantity	Frequency

Current Medications: ☐ No current medications

Medication	Dosage	Frequency	Method	Ended On

Psychosocial stressors/Contributing factors:

- ☐ Medication Noncompliance
- ☐ Recent traumatic event
- ☐ Homelessness/housing issues
- ☐ Vocational/Job Issues
- ☐ Anniversary of death/traumatic event
- ☐ Current/Chronic Medical Issues
- ☐ Pending/Current Legal Issues
- ☐ Need for medical detox from multiple substances
- ☐ Treatment Noncompliance
- ☐ Lack of community supports
- ☐ Family/Relationship Conflict
- ☐ Social environment
- ☐ Failure to respond in less intensive LOC
- ☐ Residential detox bed (SA III.7-D) unavailable
- ☐ Other: (please specify below)

_____

Date/Results of Blood Alcohol Level: **BAL Date/Time:** _____
BAL: _____

Date/Results of Toxicology Screen: **Tox Date/Time:** _____
Results: ☐ Positive ☐ Negative **Substances**:

Symptom Checklist (Select at least one – Required

- ☐ Depressed Mood
- ☐ Sleep Disturbance
- ☐ Hopelessness/helplessness
- ☐ Inadequate Self Care
- ☐ Appetite disturbance
- ☐ Recent suicide attempt(s)
- ☐ Para-suicidal behaviors
- ☐ Peer/Relationship Difficulty
- ☐ Aggression/violence toward others
- ☐ Attention/Impulse Disorder
- ☐ Confusion/Disorientation
- ☐ Panic attacks/Agoraphobia
- ☐ Obsessive/Compulsive Behaviors
- ☐ Nightmares/Flashbacks
- ☐ Hypervigilence
- ☐ Catatonia/mutism
- ☐ Acute substance withdrawal
- ☐ Alcohol and/or drug intoxication
- ☐ Substance-induced anxiety
- ☐ Substance-induced psychosis
- ☐ Substance-induced mood disorder
- ☐ Substance-related medical issues
- ☐ Other (specify):

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Describe events/symptoms/stressors necessitating admission (REQUIRED):

Requested Number of Days:	

Treatment Plan (MUST check at least one)

- ☐ Constant Observation
- ☐ 15 minute safety checks
- ☐ Family/Partner Therapy
- ☐ Psycho-education
- ☐ Psycho-pharmacology assessment
- ☐ Withdrawal management
- ☐ Medication Adjustment
- ☐ Other (specify):

Projected DISCHARGE Plan (REQUIRED)

Anticipated Discharge Date: _____

Projected Referral LOC (1): _____

(2): _____

Projected Provider Name:

Form Completed By: _____ **Telephone #:** _____ **Date:** _____

BHRP Reviews may be faxed to: Advanced Behavioral Health, Inc. at (860) 704-6145

Please keep a record of this transaction for your records