

Family Based Mental Health Services 16-Week Review

IDENTIFYING INFORMATION		
Date:	Member Name:	MA #:
		SSN:
Date of Birth/Age:	Provider:	

Requested Start Date for Authorization:		Admit Date:	
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CURRENT DIAGNOSIS	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V: (GAF Current)	
Any revision to diagnosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Member's Risk to Self: <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)	Member's Risk to Others: <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)
Has a crisis/safety plan been updated in collaboration with the family?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Number of crisis calls in the past 10 weeks:	
<i>Please describe:</i>	

Current Impairments

Key:

0 (None) 1 (Mild or Mildly Incapacitating) 2 Moderate or Moderately Incapacitating 3 (Severe or Severely Incapacitating) NA (Not Assessed)

Mood Disturbances (Depression or Mania)	Weight Loss Associated with an Eating Disorder	Anxiety
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

Medical/Physical Conditions	Psychosis/Hallucinations/Delusions	Substance Abuse/Dependence
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

Thinking/Cognition/Memory/Concentration Problems	Job/School Performance Problems	Impulsive/Reckless/Aggressive Behavior
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

Social Functioning Relationships/Marital/Family Problems	Activities of Daily Living Problems	Legal
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

LIST ONGOING GOALS / OBJECTIVES IN MEASUREABLE TERMS:

IDENTIFIED GOALS AND / OR OBJECTIVES ALREADY ACHIEVED:

CURRENT RATES OF BEHAVIOR (list each separately):

WHAT CHANGES HAVE BEEN MADE TO YOUR TREATMENT PLAN THAT WILL INCREASE THIS RATE OF COMPLIANCE:

NEW RESOURCES OR COMMUNITY SUPPORTS IDENTIFIED DURING THE FIRST 16 WEEKS (please list):

EDUCATIONAL STATUS	
Last contact with school:	
Any changes reported at school? <i>(Please list)</i>	

PROBLEMATIC BEHAVIOR CONTINUING TO PUT THE CHILD / ADOLESCENT AT RISK FOR OUT-OF-HOME TREATMENT:

CURRENT FAMILY CONCERNS / EXPECTATIONS FOR ONGOING TREATMENT:

Has child been Inpatient at any time in this past auth period? <input type="checkbox"/> YES <input type="checkbox"/> NO

MEDICATIONS		
NAME	DOSE	FREQUENCY

Prescribing psychiatrist:	
Any revision to medication in past 10 weeks? <i>(Please list)</i>	
Date of last medication monitoring appointment and with whom?	Date: _____ With: _____
Has the member / family been compliant with medications as prescribed:	<input type="checkbox"/> YES <input type="checkbox"/> NO
If no, why?	

REASON FOR CONTINUED STAY:

IDENTIFIED TREATMENT BARRIERS CONTINUING TO PREVENT PROGRESS IN TREATMENT:

BASELINE BEHAVIOR AT BEGINNING OF TREATMENT (list each identified behavior separately):

EXPECTED DISCHARGE DATE:		PLANNED DISCHARGE Level of Care:		PLANNED DISCHARGE RESIDENCE:	
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