

BEHAVIORAL HEALTH CONCURRENT CLINICAL REVIEW FORM

Please address each area. An incomplete form may result in a delay with your request.

Submit completed form to:

Email: NMTurquoiseCare@magellanhealth.com

Fax: (505) 843-3019

Date Form Completed:				
FACILITY INFORMATION				
Name of Facility:				
Out-of-State Facility?				
National Provider Identificatio	n (NPI) Number:			
	ne):			
Phone:	Fax:			
Level of Care Requested (inclu	iding billing code):			
	Requested Dates of Ser			
	 Units:			
		_		
Ŋ	MEMBER INFORMATION			
Ple	ease complete applicable fields.			
Member Name (First/Last):				
	Number:			
	Member Age:			
Guardian Phone:				
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Presbyterian exists to ensure all of the patients, members and communities we serve can achieve their best health.

Is the member involved with the New Mexico Children, Youth and Families Department (CYF) and/or Child Protective Services (CPS)? \Box Yes \Box No			
Is the member currently in the custody of CYFD? \Box Yes \Box No			
If "yes," please provide the CYFD social worker: Name: Phone:			
Is the member involved with Adult Protective Services (APS)? \Box Yes \Box No			
If "yes," please provide the APS social worker: Name: Phone:			
Is the member involved with CYFD Juvenile Justice Services (JJS)? \square Yes \square No			
If "yes," please provide the JJS social worker: Name: Phone:			
Power of Attorney: Name: Phone:			
Treatment Guardian: Name: Phone:			
Developmental Disabilities (DD) Waiver Status:			
Has the member's guardian participated in discharge planning? \Box Yes \Box No			
If "no," why not?			
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM) DIAGNOSES Current DSM Diagnosis (include DSM codes): Description of Medical Needs (including durable medical equipment [DME] and chronic/co-morbid conditions):			
REASON FOR CONCURRENT REQUEST Summary of current symptoms, behaviors and reason to continue at this level of care (specify intensity, frequency and duration):			

Has parent/guardian participated in treatment planning	g/therapy sessions? \square Yes \square No		
If "no," why not?			
Therapist: Name:	Phone:		
List individual/family therapy sessions since last revie	ew:		
MENTAL STATUS EX	KAM		
Mental Status Examination (MSE) completed by (name):			
Date Completed: If not completed, why not?			
Appearance and Behavior (posture, gestures, attire, facial expressions and speech):			
Attention (normal, altered, impaired):			
Mood (normal, euphoric, agitated, sad, etc.):			
Affect (appropriate, inappropriate, flat, etc.):			
Perception (hallucinations, delusions, etc.):			
Thought Content/Process (logical, de-realizations, suic	cidal ideation/homicidal ideation,		
etc.):			
Orientations (time, person, place, circumstances):			
Insight (good/fair/poor/absent):			
Activities of Daily Living (i.e., within normal limits, in	mpaired):		
Sleep (e.g., disturbed, early morning awakening, etc.):	:		
RISK ASSESSMEN	NT		
Does the member currently have suicidal or homicidal	ideation? ☐ Yes ☐ No		
Means:			
Motives:			
Plan/Intent:			
Current aggression that justifies level of care:			
Active Psychosis (describe):			
Other Dangerous or Self-Injurious Behaviors:			
Does the member have current substance abuse? \Box	Yes □ No		

Substance Abuse Frequency/Dura	ation:			
Substance Abuse Last Use:				
Is the member willing/able to contract for safety? \Box Yes \Box No				
CURRENT MEDICATIONS				
`	al health/substance abuse and medical)			
	Dose:			
	Date Started:			
Is member adherent to medication				
If "no," why not?				
	lude long-term goals, short-term objectives and at focus on identified problem areas in current clinical			
Other factors/pertinent information	on impacting treatment:			
	DISCHARGE PLAN			
Current Estimated Length of Stay	<i>y</i> :			
Where will member live upon dis recommended?	scharge and what level of care is preliminarily			

What resources or providers in the member's community were identified?				
Has parent/guardian agreed to the preliminary discharge	e plan?			
If "no," why not?				
Discharge Planner: Name	Phone:			
Has Managed Care Organization (MCO) care coordinator been involved with				
discharge planning? ☐ Yes ☐ No				