



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

INTENSIVE OUTPATIENT PROGRAM 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. Fax completed 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: _____

1. Date of Admission: _____ Date of intake appointment: _____ Referral Source: _____
2. Number of days requested _____ Requested review date: _____
3. Diagnoses I-V:
 - Axis I: _____
 - Axis II: _____
 - Axis III: _____
 - Axis IV: (Describe) _____
 - Axis V: Current _____ Highest in Past Year _____
4. Reason for seeking treatment including pattern and extent of recent substance use: _____
5. Third party mandated: No Yes By whom: _____
6. Treatment history/prior admissions: _____
7. Identify and provide details about risks currently present:
 - Cravings to use _____
 - Suicidal / Homicidal _____
 - Severe functional impairments / Jeopardies _____
8. Current Treatment Plan: _____
9. Current 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. Date Family Meeting Scheduled: _____
12. Current Outpatient Providers: _____
13. Any other clinical information to consider (attach additional pages if necessary): _____
14. Plan to address active substance abuse: _____



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

14. Discharge Plan: _____

15. Anticipated Discharge Date: _____

CONCURRENT REVIEW

1. Number of days used since last review: _____ Number of additional days requested: _____

2. If days missed, why _____ Excused? Yes No

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

4. Identify which risks are currently present and how the risk is being addressed (specify any incidents or relapses since start of program):

Craving to use _____

Suicidal / Homicidal _____

Severe functional impairments _____

5. Current Treatment Plan: _____

6. Date Family Meeting Scheduled: _____

7. Contacts with and recommendations of the outpatient providers: _____

8. Current Psychiatric Medications: _____

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

10. Discharge Plan: _____

11. Anticipated Discharge Date: _____

DISCHARGE REVIEW

1. Date of last attendance: _____ Number of days used: _____ Type of discharge: Regular Admin AMA

2. Discharge Diagnoses I-V:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current _____ Highest in Past Year _____

3. Discharge Medications and Dosages: _____

4. Level of Care after Discharge: _____

5. Names of providers for aftercare: _____

6. Dates of appointments with aftercare providers: _____

7. Involvement/role of family and/or significant other in aftercare plan: _____