Banner University Health Plans

Concurrent Inpatient Review Form

This form is to be TYPED.

Email the completed form to BUHPBHUMPAMailbox@bannerhealth.com on the date of review.
Cc: A copy of the form to your current health plan re viewer

AHCCCS Number:	Member Name:	Today's Date:
Facility name:	Date of Birth:	❑ Child ❑ Adult

General Information

Admit Date:	Admission Diagnosis:
Has there been a change to court order status? ❑ Yes ❑ No	
If yes, current status: Court Order Type: ❑ COE ❑ COT ❑ RCOT ❑ Voluntary Select One	Date of status change: Date of Hearing:
Member and/or guardian's primary language is:	
Does member have: ❑ Guardian ❑ Durable power of attorney ❑ N/A Contact information for guardian / DPOA (if applicable):	
Name of Outpatient Provider:	Phone Contact of Outpatient Provider:
If no Outpatient Provider, Date urgent enrollment has been requested:	
Current Attending BHMP:	
Facility UM Reviewer Name:	Phone:
Email address:	

Type of Admission: Behavioral, Detox, Both or Eating Disorder

Select One

BH Diagnosis update if it has changed:

Lab results (including medication related):

If the request is for eating disorders, please attach full labs

<u>If not provided at previous review, please indicate:</u>

- **Blood Alcohol Level:**
- **UA/UDS/Utox Results:**

<u>If detox is being provided, update with current information:</u>

- **Msas/CIWA Score:**
- **COWS/CINA Score:**

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Vitals are for Detox and Eating Disorder

Temperature:

Heart Rate:

Respiratory Rate:

Blood Pressure:

Standing:

Sitting:

Justification for continued stay

Acute detox symptoms, including withdrawal symptoms present (in past 24 hours) ❑ **N/A or details:**

Any change to treatment protocol and expected duration: ❑ **N/A or details:**

Current acute symptoms & MSE: ❑ **N/A or description:**

Clinical Update

From MD Notes including date:

Changes/improvements since last review (be specific):

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Current Medications

Medication/Dose/Frequency/Compliant: Please note if medication is PRN.

Medications	Dose	Frequency	Compliant	PRN (Y or N)	Note Date of Changes	Increase, Decrease or Discontinued
1.	1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.	2.
3.	3.	3.	3.	3.	3.	3.
4.	4.	4.	4.	4.	4.	4.
5.	5.	5.	5.	5.	5.	5.

If requesting ECT, date of submission of prior authorization:

DCS concerns have been identified, date and time of DCS report:

If DCS report has not been made, please identify the rationale:

Updated Treatment Plan to Address Precipitating Event & current presentation:

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Discharge Plan

1.

2.

3.

Barriers to Discharge:

How are the barriers being addressed:

Do you need assistance with discharge coordination? ❑ yes ❑ no
If yes, please provide the name/title/email/phone number of the person our discharge coordinator can contact:

Discharge Planning

ELOS:	Expected D/C date:

Date the most recent discharge planning/ART/CFT meeting was held?

Who was present for the discharge meeting:

What discharge follow up appointments have been made:

Service:	Provider:	Date of Appointment:
1.	1.	1.
2.	2.	2.
3.	3.	3.

If plan is to step down to an out of home level of care, What facilities have been contacted, When were they contacted, and What was the outcome?

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Discharge Planning Cont.

Do you have any additional information that you would like to provide to support continued stay at this level of care?

For Concurrent Review, please answer any questions or address recommendations from the Banner reviewer that are below this line.