Out of Home Concurrent Review Form

Banner University Health Plans
Banner – University Family Care

This form is to be TYPED.

Send completed form by fax to the BUHP Behavioral Health Department at (520) 874-3411 or BUHPBHUMPAMailbox@bannerhealth.com .

Today's Date:_____

Member Name:_____ Date of Birth: _____

Outpatient Agency:_____ Outpatient CM: _____

OOH Provider Agency:_____

OOH Type: ☐BHIF ☐ BHRF ☐ HCTC

Name of Specific Home/Facility: _____

Date of admission:_____ Last Covered Day:_____ Reviewed Period: From_____ To_____

OOH Agency Reviewer:_____ Phone #: _____

Clinical Update:

1. What are the **current** target symptoms/behaviors being addressed in this level of care:

   _____
   _____
   _____

2. List each observable, measurable goal being addressed and progress towards its completion. If there are more goals, please list each one and describe the progress.

Goal #1:	
Progress:	
Goal #2	
Progress:	
Goal #3	
Progress	

Member's Name: _____

3. **What is the member's current level of functioning? If not documented above, include information on ADLs, interpersonal interactions, and/or work performance.**

_____
_____
_____

4. **What interventions [<u>not services</u>] were used during this reporting period to address thecurrent target symptoms and accomplish the above goals?**

_____
_____
_____

5. **What family or other natural supports occurred during this reporting period?**

_____
_____
_____

6. **What were the dates and outcomes of the clinical team meetings (CFT or ART's) during this reporting period?**

_____
_____
_____

7. **Current Diagnosis:**

Psychiatric Diagnosis: _____

Medical Diagnosis: _____

8. **What are the member's current medications:**

Psychotropic Medications with directions	Medical Medications with directions

Member's Name: _____

Discharge Planning Update:

1. **What is the targeted level of functioning for the member to be considered ready for discharge? This must be observable, measurable terms.**

   _____
   _____
   _____

2. **How does the member's current level of functioning prevent him/her from returning to the community with outpatient services and supports?**

   _____
   _____
   _____

3. **How many more days of service are being requested to reach the targeted level of functioning?**

   _____
   _____
   _____

4. **What is the specific discharge plan? Include the specific living arrangement as well as the planned outpatient services and supports and their frequency after discharge.**

   _____
   _____
   _____

5. **Are there any barriers to implementing the discharge plan at this time? If YES, list the specific barrier(s) and outline the intervention(s) planned to remove it/them.**

   _____
   _____
   _____