

VIVA HEALTH CONTINUED STAY REVIEW FAX FOR MENTAL HEALTH TREATMENT

Telephone: (205) 933-1201

Fax Completed Information To: (205) 449-7049

Patient Name:		Contract Name:		DOB:	Date of Admission:
Patient Phone # (Required) :		ID#:			
Facility Name:		Program Type: D IP D PHP D IOP		Attending MD:	
Date of Review:		Estimated Length of Stay:		Phone #:	
Key Symptoms/Behaviors Targeted by Current Treatments:					
Clinical Progress or Regress Since Last Review/Other Problems Not Cited Above:					
Prior Treatment History:					
Social/Family History:					
History of ETOH & Other Psychoactive Substances:					
ETOH Level:		Drug Screens:		Toxicity Screens:	
MD Orders (Medications, Precautions, Type of Unit):					
Physical & Mental Status Assessment:					
Current VS: T _____ P _____ RR _____ B/P _____ HT _____ WT _____					
Recent Weight Change?					
Clinical Factor(s) That Make Lower Levels of Care (e.g. Rx & Individual/Family Therapy, Etc.) Either Unsafe or Unfeasible:					
Discharge Plan:					
Required: After Care Plan (Including Follow-up Instructions and D/C Medications):					
Required: Please Send a Copy of the Face Sheet and a Copy of the H & P With the Completed Form					
UR Contact:		Phone #:		Fax #:	
FOR VIVA HEALTH USE ONLY					
Date of Next Review:			Total Days Certified:		

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Payment of benefits is subject to eligibility at the time services are rendered according to the terms of the benefit contract.

Patient Name:		ID #:
DIAGNOSTIC ASSESSMENT		
	Presenting Complaints or Conditions	Notes
Risk (Intent, Thought, Means, Plan)	Suicide Homicide Other Risky Behavior(s)	
Mood	Normal Anxious Hypomanic Depressed Manic Other	
Thoughts	Normal Hallucinations --Auditory --Tactile, --Visual --Gustatory Olfactory Suspicious Delusions Other	
Sleep	Undisturbed Frequent Awakening Early AM Awakening Insomnia Difficulty Falling Asleep Hypersomnia Nightmares Other	
Behavior	Aggressive Compulsive Reckless Other	
Appetite	Good Bulimia Anorexia	
ADL	Hygiene Bathing Other	
NOTES:		

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