



**Psychiatric Review Worksheet
for
Concurrent Review (All Ages)**

Your Name: _____ Tel #: _____ FAX # _____

Today's Date: _____ NPI #: _____

Facility: _____

Participant's Name: _____

Participant's Address: _____

Medicaid #: _____ Admit Date _____ Reference #: _____

Number of Days Requested _____ Would you like reply by phone or FAX? _____

Anticipated DC date, plan, follow-up: _____

Address questions from last review: _____

Medication orders, changes, levels: _____

Precautions, level changes: _____

Test results: _____

Names of groups (first concurrent): _____

Inpatient necessity (behaviors; unit and school performance): _____



Mental status (mood, affect, thought disorders): _____

Participation, investment, insight: _____

Progress towards stabilization/benefit from treatment: _____

Treatment plan: _____

Family (or equivalent) involvement; appropriate discharge preparation: _____

Other pertinent information: _____

Information needed (next review): _____

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