VIVA HEALTH CONTINUED STAY REVIEW FAX FOR SUBSTANCE ABUSE TREATMENT
Telephone: (205) 933-1201
Fax Completed Information To: (205) 449-7049

Patient Name: **Patient Phone # *(Required)*:**	**Contract Name:** **ID #:**	**DOB:**	**Date of Admission:**
Facility Name: **Date of Review:**	**Program Type:** ☐ IP ☐ PHP ☐ IOP **Estimated Length of Stay:**	**Attending MD:** **Phone #:**	

1. Present Mental Status:

2. Any Current Cravings Noted? ☐ **YES** ☐ **NO**

3. Any Signs or Symptoms of Withdrawal? ☐ **YES** ☐ **NO** **If So, Please Explain:**

4. Urine Drug Screen ☐ **YES** ☐ **NO** **Date:** **Results:**

5. Are Vital Signs Stable? ☐ **YES** ☐ **NO** **If Not, Please Explain:**

6. Changes In Medications:

7. Please List Any New Clinical Information (i.e. Psych Testing Results, Axis Changes, Etc.)

8. Are There Any Life-Threatening Toxic Effects? ☐ **YES** ☐ **NO** **If So, Please List:**

TREATMENT INFORMATION AND COMPLIANCE—*If The Answer To Any of The Below Is "No," Please Explain*

1. Has Patient Found a Sponsor? ☐ **YES** ☐ **NO** **If So, Is The Sponsor** ☐ **Temporary** ☐ **Permanent**

2. How Many Days Per Week Is The Patient Required To Attend Treatment? **Is The Patient Attending All Days?** ☐ **YES** ☐ **NO**

3. Has Patient Completed And Turned In All Required Work? ☐ **YES** ☐ **NO**

4. Is Patient Participating And Verbalizing In Group/Individual Therapy? ☐ **YES** ☐ **NO**

5. Please Describe Overall Progress In Therapy:

6. Has Patient Attended Required Outside AA Meetings? ☐ **YES** ☐ **NO**

7. Can Effective Treatment Be Rendered At A Lower Level of Care? ☐ **YES** ☐ **NO**

PATIENT SUPPORT SYSTEM ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed**
What Is Patient Support System At This Time?

Has The Family/Support System Attended Any Family Education And Support Sessions? ☐ **YES** ☐ **NO**

Discharge Plan: **Discharge Date:**

Post-Discharge, What Will Patient's Living Arrangement Be (i.e. home, halfway house, etc.)?
***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 **SA Benefit:**

PHP Days Used: **IOP Days Used:** **Next Review Date:** **RN:**