VIVA HEALTH

VIVA HEALTH INITIAL REVIEW FAX FOR MENTAL HEALTH TREATMENT
Telephone: (205) 933-1201
Fax Completed Information To: (205) 449-7049

Patient Name: **Patient Phone # *(Required)*:**	**Contract Name** **ID#:**	**DOB:**	**Date of Review:**

Does the Patient Have Any Additional Coverage? ☐ Yes ☐ No **Primary:** _____ **Secondary:** _____ **Other:**	**Is the Patient a Licensed Practitioner (eg., RN, LPN, etc.)** ☐ Yes ☐ No **If Yes, Specify Licensure:** _____ **Has the State Licensure Board Been Notified?** ☐ Yes ☐ No **Does the Patient's Employment Cause Him/Her to Fall Under DOT Regulations?** ☐ Yes ☐ No
Facility Name: **Date of Admission:**	**Attending MD:** **Phone #**

Program Type: ☐ IP ☐ PHP ☐ IOP
For PHP or IOP, please check days patient is attending: ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
Estimated Length of Stay:

Admitting Diagnosis/AXIS: **I.** **IV.**
II. **V.**
III.

Prompt For Help: Pt's Motivation To Seek Treatment:

History:

1. **How was patient admitted (e.g. ER, direct admit, step-down, etc.)?**
2. **Legal issues (e.g. court hold, etc.):**
3. **If disabled, on what basis?**

Stressors: Life Role Dysfunction (School, Employment, Financial, Legal And How Severe) With Examples:

Chemical Or ETOH Use:
Urine Drug Screen: **Toxicity Screen:** **ETOH Level:**

MD Orders (Medications, Precautions, Type of Unit):

Defined Tx Plan:

Physical & Mental Status Assessment:
Admitting VS: T_____P_____RR_____B/P_____WT_____ Recent Weight Change?_____

Social/Family History:

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:**

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 Depressed Anxious Manic Hypomanic Other	
Thoughts	Normal Suspicious Hallucinations Delusions --Auditory --Tactile, --Visual --Gustatory Olfactory Other	
Sleep	Undisturbed Insomnia Frequent Awakening Difficulty Falling Asleep Early AM Awakening Hypersomnia Nightmares Other	
Behavior	Aggressive Compulsive Reckless Other	
Appetite	Good Bulimia Anorexia	
ADL	Hygiene Bathing Other	
NOTES:		

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