

VIVA HEALTH INITIAL REVIEW FAX FOR MENTAL HEALTH TREATMENT Telephone: (205) 933-1201

Fax Completed Information To: (205) 449-7049

Patient Name:	Contract Name		DOB:	Date of Review:
Patient Phone # (<i>Required</i>):	ID#:			
Does the Patient Have Any Additional Coverage?	res □ No	Is the Patient a Licensed Pract	itioner (eg., RN, LPN, etc.)	□ Yes □ No
Primary:		If Yes, Specify Licensure:		
Secondary:		Has the State Licensure Board		□ Yes □ No
Other:		Does the Patient's Employmen Under DOT Regulations?	t Cause Him/Her to Fall	□ Yes □ No
Facility Name:		Attending MD:		
Date of Admission:		Phone #		
	I IP □ PHP	□ IOP		
For PHP or IOP, please check days patient is attending:	I 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-do	wn, etc.)?			
2. Legal issues (e.g. court hold, etc.):	,,.			
3. If disabled, on what basis?				
of It districtly of what busists				
Stressors: Life Role Dysfunction (School, Employment, Fina	ancial, Legal And How	Severe) With Examples:		
• • • • • • • • • • • • • • • • • • • •	, 0	•		
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:				
			Recent	
Admitting VS: TPRR	B/P_	WT	Weight Change?	
Social/Family History:				
Discharge Plan:				
Discussion in the second secon				
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				
TOR (1) III III III OOD OILD I		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..

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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 AuditoryTactile,VisualGustatory Olfactory Other				
Sleep	Undisturbed Insomnia Frequent Awakening Difficulty Falling Asleep Early AM Awakening Nightmares Other				
Behavior	Aggressive Compulsive Reckless Other				
Appetite	Good Bulimia Anorexia				
ADL	Hygiene Bathing Other				
NOTES:					

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