Vaya Health

Inpatient Concurrent Review Form

Patient last name:	Patient first name:	Patient middle name:	Patient DOB:
Inpatient provider name:	Treatment team contact name, credentials and phone #:		
Physician name:	Physician phone #:		
Date of admission:	Reason for admission:		
Diagnosis(es): 1. 2. 3.	Current authorization expiration date: ☐ N/A		

REASONS FOR REQUESTING CONTINUED STAY:

☐ ***Current*** **risk factors**

☐ **Risk to self** ☐ **Risk to others** ☐ **Bizarre behavior** ☐ **Psychosis and/or inability to care for self** ☐ **Other**

Describe risks in detail:

☐ **Has not achieved treatment goals**

	Goal	Treatment intervention	Progress/barriers
1			
2			
3			

CURRENT MEDICATIONS (if not already included in SAR):

Medication, dosage and frequency	Start date	Has dosage or frequency changed since last request?
		☐ No ☐ Yes, describe:
		☐ No ☐ Yes, describe:
		☐ No ☐ Yes, describe:
		☐ No ☐ Yes, describe:
		☐ No ☐ Yes, describe:
		☐ No ☐ Yes, describe:

SUBSTANCE USE INFORMATION (Complete for all SUD patients):

***Current* vital signs:** **BP:** **Temp:** **Pulse:** **Resp:** **BAL:**	
Current withdrawal symptoms: ☐ **Agitation** ☐ **Cramping** ☐ **DTs** ☐ **Seizures** ☐ **Hallucinations** ☐ **Nausea** ☐ **Sweating** ☐ **Tremors** ☐ **Vomiting** ☐ **Other:**	
Clinical Institute Withdrawal Assessment (CIWA) score:	**Clinical Opiate Withdrawal Scale (COWS) score:**
Urine drug screen: **Date:** **Results:**	

DISCHARGE PLAN:

Planned date of discharge:	**Planned discharge Level of Care:** ☐ Inpatient ☐ Residential treatment facility ☐ Partial hospitalization ☐ IOP ☐ Outpatient ☐ Other:
Barriers to discharge (if applicable):	
Discharge living arrangement: ☐ **Family home** ☐ **Alone** ☐ **W/ others** ☐ **Shelter** ☐ **Correctional facility** ☐ **Foster home** ☐ **Group home** ☐ **Halfway house** ☐ **Other:**	

ADDITIONAL INFORMATION: