Banner University Health Plans

Initial Facility Inpatient Review Form

This form is to be TYPED.

Email the completed form to BUHPBHUMPAMailbox@bannerhealth.com on the date of review.
Cc: A copy of the form to your current health plan reviewer

Today's Date:		
AHCCCS Number:	**Member Name:**	
Facility Name:	**Date of Birth:**	❑ Child ❑ Adult
Parent/Guardian Name:		
Mental Health POA: ❑ Yes ❑ No	**Guardian Phone Number:**	
Member and/or Guardian's Primary Language:		

General Information

Admit Date:	
Is there a Court Ordered status: ❑ COE ❑ COT ❑ RCOT ❑ Voluntary Select One	**Date of Status:**
Legal issues impacting treatment or discharge: **Please forward the court documents to your reviewer**	
DCS Involvement? ❑ Yes ❑ No	

Facility Information

Attending BHMP:	
Facility UM Reviewer Name:	**Phone Number:**
Email Address:	
Discharge planner/Social Worker Name:	
Phone Number:	**Email Address:**

Insurance Information

Other Insurance Name:	**ID #:**
How many lifetime Medicare days are available:	
Primary Care Physician Name:	**Phone Number:**
Current BH Provider:	**Date of Contact:**
Date of Urgent Enrollment Request:	**Date of Urgent Enrollment Completion:**

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Date of scheduled Discharge Planning meeting/ART/CFT:	
Date H&P completed:	**Date Psych Eval completed:**

Living Situation Prior to this Admission: SNF, Home, Residential, Homeless or unknown Select One
What specific event occurred just prior to this admission that lead to the admission:
What supports does the member have (include natural):
Admission criteria:
Dates of Previous Inpatient Admissions:

Type of Admission: Behavioral, Detox, Eating Disorder or Both Select One
BH diagnoses: **Primary:** **Secondary:** **Tertiary:**
Medical Diagnoses:

Substance Used	How Much	How Often	Route	Date of Last Use
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.
4.	4.	4.	4.	4.

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Admission Cont.

If admission is for detox, please answer the following:

Blood Alcohol Level:

UA/UDS/UTOX Results:

History of Withdrawal Seizures: ☐ Yes ☐ No

History of Blackouts: ☐ Yes ☐ No

History of Delirium Tremens: ☐ Yes ☐ No

Admit MSAS/CIWA Score:

Admit COWS/CINA Score:

Complete Vitals for Detox or Eating Disorders

Vitals:

Temperature:

Heart Rate:

Respiratory Rate:

Blood Pressure:

Standing:

Sitting:

What withdrawal symptoms are present?

What is the treatment protocol and expected duration?

----------End of Detox Section----------

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Complete Vitals for Detox or Eating Disorders Cont.

Pertinent Lab results (including medication related): If the request is for eating disorders, please attach full labs.

Has there been acute psychosis/HI/SI within last 24 hours? ❑ **Yes** ❑ **No**

Current acute symptoms & MSE:

From MD Notes including date:

Medications patient was taking prior to admission:

Current Medications

Medication/Dose/Frequency/Compliant: Please note if medication is PRN.

Medications	Dose	Frequency	Compliant	PRN (Y or N)	Note Date of Changes	Increase, Decrease or Discontinued
1.	1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.	2.
3.	3.	3.	3.	3.	3.	3.
4.	4.	4.	4.	4.	4.	4.

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Current Medications Cont.

If requesting ECT, date of submission of prior authorization:

Treatment Plan to Address Precipitating Event & current presentation:

Discharge Plan

1.

2.

3.

If plan is to step down to an out of home level of care, What facilities have been contacted, When were they contacted, and What was the outcome?

Barriers to Discharge:

How are the barriers being addressed:

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Discharge Plan Cont.

If discharge appointments have been made, please list the service, provider, and date of appointment:

Service:	Provider:	Date of Appointment:
1.	1.	1.
2.	2.	2.
3.	3.	3.

Do you need assistance with discharge coordination? ❑ yes ❑ no
If yes, please provide the name/title/email/phone number of the person our discharge coordinator can contact:

ELOS:

Expected D/C Date:

Any additional information that you would like to provide contributing to medical necessity and need for acute psychiatric inpatient hospitalization: