



One Monarch Place · Suite 1500
 Springfield, MA 01144-1500
 413.787.4000 · 800.842.4464 · hne.com

INPATIENT DETOXIFICATION CLINICAL REVIEW FORM

BEHAVIORAL HEALTH DEPARTMENT
PHONE: (413) 787-4000, EXT. 5028 FAX: (413) 233-2800

The following information is required for reviews. Please complete thoroughly. If any of these questions are not applicable, please indicate. Fax completed form to the HNE Behavioral Health Department at 413-233-2800.

INITIAL CLINICAL REVIEW

Facility Name: _____ Phone: _____
 Attending Provider (MD) Name: _____ Phone: _____
 Utilization Review Contact: _____ Phone: _____ Fax: _____
 Member Name: _____ Date of Birth: _____
 HNE Member ID#: _____ Today's Date: _____

1. Date of Admission: _____ Date of intake appointment: _____ Referral Source: _____
4. Diagnoses I-V:
 - Axis I: _____
 - Axis II: _____
 - Axis III: _____
 - Axis IV: (Describe) _____
 - Axis V: Current _____ Highest in Past Year _____
5. Precipitating reason for admission: _____
6. CIWA or COWS Score: _____ Signs and symptoms for which member is scoring _____
7. Vitals: BP _____ Pulse _____ Respiration _____ Temp _____
8. Current treatment plan including detox protocol, and type and amount of medication given to date: _____
9. Treatment history/prior admissions: _____
10. Identify which risks are currently present and how the risk is being addressed:
 - History of DTs or grand mal seizures (specify with dates): _____
 - Suicidal / Homicidal _____
 - Severe functional impairments / Jeopardies _____
 - Other _____
11. Substances used and for which detoxification is required (Specify amount, frequency and duration of use): _____
12. Psychiatric Medications: _____
13. Date Family Meeting Scheduled: _____
14. Current Outpatient Providers: _____
15. Any other clinical information to consider (attach additional pages if necessary): _____



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Member Name: _____ **Date of Birth:** _____ **HNE Member ID#:** _____

16. Discharge Plan: _____

17. Anticipated Discharge Date: _____

CONCURRENT REVIEW

1. If any change in Diagnosis, please identify and comment: _____

2. Identify which risks are currently present and how the risk is being addressed:

History of DTs or grand mal seizures (specify with dates): _____

Suicidal / Homicidal _____

Severe functional impairments / Jeopardies _____

Other _____

3. CIWA or COWS Score: _____ Signs and Symptoms for which member is scoring _____

4. Vitals: BP _____ Pulse _____ Respiration _____ Temp _____

5. Current treatment plan including detox protocol, and type and amount of medications given during review period: _____

6. Date Family Meeting Scheduled: _____

7. Current Psychiatric Medications: _____

8. Any other Clinical information to consider (attach additional pages if necessary): _____

9. Discharge Plan: _____

10. Anticipated Discharge Date: _____

DISCHARGE REVIEW

1. Discharge Date: _____ Type: Regular Admin AMA ACA

2. Discharge Diagnoses I-V:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current _____

3. Level of Care after Discharge: Check one: Rehab PHP IOP Facility name: _____ Start date: _____

OP, then: Therapist's name _____ Date/Time: _____

Psychiatrist's or med provider's name: _____ Date/Time: _____

4. Discharge Psychiatric Medications and Dosages: _____

5. Involvement/role of family and/or significant other in aftercare plan: _____

6. Member's Contact Info: Home #: _____ Cell #: _____

7. Is a member having any barriers to follow-up care ex: transportation, financial, language, finding a provider, etc.

(Note: Please contact HNE (413) 787.4000 ext 5028, if you need assist with helping mbr find an in-plan provider.)