



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

PARTIAL HOSPITAL PROGRAM 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: _____
2. Number of days requested: _____ Requested review date: _____
3. Diagnoses I-V:
 - Axis I: _____
 - Axis II: _____
 - Axis III: _____
 - Axis IV: (Describe) _____
 - Axis V: Current _____ Highest in Past Year _____
4. Reason for seeking treatment: _____
5. Treatment history/prior admissions: _____
6. Identify and provide details about risks currently present:
 - Suicidal _____
 - Homicidal _____
 - Severe functional impairments _____
 - Other _____
7. Current Treatment Plan: _____
8. Current Psychiatric Medications: _____
9. If the member is non-compliant with medications when indicated or is otherwise non-compliant with treatment, what is the plan to address the issues? _____
10. Any other clinical information to consider (attach additional pages if necessary): _____
11. If applicable, information about active substance abuse: _____
12. Date Family Meeting Scheduled: _____
13. Current Outpatient Providers: _____



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

14. Discharge Plan: _____
15. Anticipated Discharge Date: _____

CONCURRENT REVIEW

1. Number of days used since last review: _____ Number of additional days requested: _____
2. If days missed, why _____ Excused Yes No
3. If any change in diagnosis, please identify and comment: _____
4. Identify which risks are currently present and how they are being addressed (specify any incidents since start of program): _____
 Suicidal _____
 Homicidal _____
 Severe functional impairments _____
 Other _____
5. Current Treatment Plan: _____
6. Date Family Meeting Scheduled: _____
7. Contacts with and recommendations of the outpatient providers: _____
8. Current Psychiatric Medications: _____
9. Any other clinical information to consider (attach additional pages if necessary): _____
10. Discharge Plan: _____
11. Anticipated Discharge Date: _____

DISCHARGE REVIEW

1. Last date of attendance: _____ Number of days used: _____ Type of discharge: _____
2. Discharge Diagnoses I-V: _____ Regular Admin AMA
 Axis I: _____
 Axis II: _____
 Axis III: _____
 Axis IV: _____
 Axis V: Current _____ Highest in Past Year _____
3. Discharge Psychiatric Medications and Dosages: _____
4. Level of Care after Discharge: _____
5. Names of providers for aftercare: _____
6. Dates of appointments with aftercare providers: _____
7. Involvement/role of family and/or significant other in aftercare plan: _____