Blue Care Network of Michigan
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BCN Behavioral Health Inpatient Concurrent Review Form

Review date:		**Member name:**					**Member ID #:**			
Diagnosis:		**Provider NPI:**		**Provider tax ID:**			**DSM-IV code:**			
Provider name:							**Telephone #:**			
Therapist name:					**Reviewer name:**					
Date(s) of service:										

PCP name:	**PCP release:**	☐ **Offered / signed**	**Date:**
Date PCP communication occurred:		☐ **Offered / declined**	**Date:**

Problems, symptoms, need for continued care

Presenting problem (include precipitant to admission):

Current symptoms (include list of specific symptoms in the last 24 hours):

Baseline functioning (describe patient's typical functioning prior to onset of symptoms):

Justification for continued stay (include reason patient continues to need this level of care):

Barriers to discharge (please circle whether barrier is an issue / is not an issue and document plan to address).

Housing	**Check one:** ☐ issue / ☐ not an issue
	Plan to address:
Poor supports	**Check one:** ☐ issue / ☐ not an issue
	Plan to address:
Lack of family involvement	**Check one:** ☐ issue / ☐ not an issue
	Plan to address:
Noncompliance with treatment	**Check one:** ☐ issue / ☐ not an issue
	Plan to address:

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Barriers to discharge continued (please circle whether barrier is an issue / is not an issue and document plan to address).	
Job jeopardy	**Check one:** ☐ issue / ☐ not an issue
	Plan to address:
Safety plan	**Check one:** ☐ issue / ☐ not an issue
	Plan to address:
Transportation issues	**Check one:** ☐ issue / ☐ not an issue
	Plan to address:
Other: _____	**Check one:** ☐ issue / ☐ not an issue
	Plan to address:

Goals of treatment for this level of care (include list of active interventions that will address the reason for admission, current symptoms, and problems).	
Goal 1	**Statement of goal:**
	Plan for achieving goal:
	Progress:
Goal 2	**Statement of goal:**
	Plan for achieving goal:
	Progress:
Goal 3	**Statement of goal:**
	Plan for achieving goal:
	Progress:
Goal 4	**Statement of goal:**
	Plan for achieving goal:
	Progress:
Medication(s): (include dosages/changes)	
Additional days requested for current level of care:	

Discharge information						
Discharge plan:			**Anticipated discharge date**:			
Follow-up appointments:	***Provider type***	***Name***	***Telephone #***	***Date***	***Time***	
	Therapist/Program:					
	Psychiatrist:					

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