

VIVA HEALTH CONTINUED STAY REVIEW FAX FOR SUBSTANCE ABUSE TREATMENT

Telephone: (205) 933-1201

Fax Completed Information To: (205) 449-7049

Patient Name:	Contract Name:	DOB:	Date of Admission:
Patient Phone # (Required) :	ID #:		
Facility Name:	Program Type: <input type="checkbox"/> IP <input type="checkbox"/> PHP <input type="checkbox"/> IOP	Attending MD:	
Date of Review:	Estimated Length of Stay:	Phone #:	

1. Present Mental Status:
2. Any Current Cravings Noted? YES NO
3. Any Signs or Symptoms of Withdrawal? YES NO If So, Please Explain:
4. Urine Drug Screen YES NO Date: Results:
5. Are Vital Signs Stable? YES NO If Not, Please Explain:
6. Changes In Medications:
7. Please List Any New Clinical Information (i.e. Psych Testing Results, Axis Changes, Etc.)
8. Are There Any Life-Threatening Toxic Effects? YES NO If So, Please List:

TREATMENT INFORMATION AND COMPLIANCE—If The Answer To Any of The Below Is "No," Please Explain

1. Has Patient Found a Sponsor? YES NO If So, Is The Sponsor Temporary Permanent
2. How Many Days Per Week Is The Patient Required To Attend Treatment? Is The Patient Attending All Days? YES NO
3. Has Patient Completed And Turned In All Required Work? YES NO
4. Is Patient Participating And Verbalizing In Group/Individual Therapy? YES NO
5. Please Describe Overall Progress In Therapy:
6. Has Patient Attended Required Outside AA Meetings? YES NO
7. Can Effective Treatment Be Rendered At A Lower Level of Care? YES NO

PATIENT SUPPORT SYSTEM Single Married Divorced Widowed

What Is Patient Support System At This Time?

Has The Family/Support System Attended Any Family Education And Support Sessions? YES NO

Discharge Plan: Discharge Date:

Post-Discharge, What Will Patient's Living Arrangement Be (i.e. home, halfway house, etc.)?


Required: After Care Plan (Including Follow-up Instructions and D/C Medications):

Required: Please Send a Copy of the **Face Sheet** and a Copy of the **H & P** With the Completed Form

UR Contact: Phone #: Fax #:

FOR VIVA HEALTH USE ONLY SA Benefit:

PHP Days Used: IOP Days Used: Next Review Date: RN:

 **CONFIDENTIALITY NOTE:** Confidentiality Notice: The information transmitted with this facsimile is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately and destroy the related message.

Payment of benefits is subject to eligibility at the time services are rendered according to the terms of the benefit contract.