



MAGELLAN HEALTH SERVICES

TRANSITION REVIEW FORM

- Area 4 (1/1/07)
 Area 9
 Child Welfare

I. Demographic Information

- a. Enrollee Name _____
- i. Enrollee Medicaid # _____
- ii. Date of Birth _____
- iii. Address _____
- iv. Phone # _____

II. Provider Name _____ / Agency _____

Degree / Title _____

Address _____

Telephone # _____

Fax # _____

E-mail _____

III. Clinical Information

- a. Current DSM IV-TR Diagnosis?

Indicate Primary Diagnosis: _____

	CODE	DESCRIPTION
I.		
II.		
III.		
IV.	Current Psychosocial Stressor(s):	
V.	GAF (Current):	GAF (Past Year):

- b. Risk Assessment (suicidal/homicidal ideation, intent, plan, means, access to means, history of suicide attempts/violence, risk factors, risk inhibitors)

Enrollee Name: _____

c. Medical /Health Issues

d. Current Medications (name, dose, frequency)

e. Alcohol/Drug Use (history, type, frequency, amount, last use, current use)

f. Psychosocial Summary (living arrangements, educational/occupational history, cultural issues, legal involvement)

g. School (current grade, academic progress, learning disabilities, behavioral issues)

h. Support System (family members, church, neighbors, peers/friends, etc.)

i. Current Providers (mental health, substance abuse, social agencies)

Enrollee Name: _____

j. Strengths (personal/social/environmental)

k. Current Behavioral Aspects of Functional Impairment

Therapeutic Behavioral On-site Services TBOS

I. Date of Initiation of TBOS Services _____

II. Reasons for Requested Service

III. Behavioral-based Goals/Progress

IV. Barriers to Progress and Goal Achievement / Plans to Address Barriers

V. Level of Enrollee/Family Participation (attendance, motivation, adherence, family/significant other involvement)

VI. Discharge Plan (How is reason for service being addressed? Discharge goals? Estimated length of service?)

Enrollee Name: _____

VII. Authorization Request

Therapy

a) Frequency (how many units per month?) _____

b) Duration (up to three months) _____

Behavior Management

a) Frequency (how many units per month?) _____

b) Duration (up to three months) _____

Therapeutic Support Services

a) Frequency (how many units per month?) _____

b) Duration (up to three months) _____

Psychosocial Rehabilitation

I. Date of Initiation of Psychosocial Rehabilitation Services _____

II. Reasons for Requested Service

III. Behavioral-based Goals/Progress

IV. Barriers to Progress and Goal Achievement / Plans to Address Barriers

V. Discharge Plan (How is reason for service being addressed? Discharge goals? Estimated length of Service?)

VI. Authorization Request

a. Frequency (how many units per month?) _____

b. Duration (up to three months) _____

Enrollee Name: _____

Day Treatment

I. Date of Initiation of Day Treatment Services _____

II. Reasons for Requested Service

III. Behavioral-based Goals/progress

IV. Barriers to Progress and Goal Achievement / Plans to Address Barriers

V. Discharge Plan (How is reason for service being addressed? Discharge goals? Estimated length of Service?)

VI. Authorization Request

- a) Frequency (how many units per month?) _____
- b) Duration (up to three months) _____

Targeted Case Management/Intensive Case Management (TCM/ICM)

I. Date of Initiation of Targeted Case Management Services _____

II. Reasons for Requested Service

III. Behavioral-based Goals/Progress

Enrollee Name: _____

IV. Barriers to Progress and Goal Achievement / Plans to Address Barriers

V. Discharge Plan (How is reason for service being addressed? Discharge goals? Estimated length of Service?)

VI. Authorization Request

TCM ICM (Not applicable for Child Welfare)

a) Frequency (how many units per month?) _____

b) Duration (up to six months) _____

Provider Name (type or print clearly): _____

Provider Signature: _____

Date: _____