

**THERAPEUTIC GROUP CARE  
INITIAL REVIEW**

**Client Demographic Information:**

Enrollee Name: \_\_\_\_\_  
Enrollee Medicaid #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Current Provider and  
Level of Care: \_\_\_\_\_  
Address/Phone #: \_\_\_\_\_

**1. Call Demographics:**

Date called to Magellan: \_\_\_\_\_  
Name of Coordinator: \_\_\_\_\_  
Response/review appt  
date and time: \_\_\_\_\_  
Follow up issues: \_\_\_\_\_  
\_\_\_\_\_

**2. Requested Level/Service:**

Provider Name: \_\_\_\_\_  
Address/Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Phone #/Email: \_\_\_\_\_  
Fax #: \_\_\_\_\_  
Requested Begin Date: \_\_\_\_\_

**3. Reason for requested service (referral source, why now)?**

\_\_\_\_\_  
\_\_\_\_\_

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**4. Clinical Diagnosis (all five axes):**

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

**5. Risk Assessment (e.g. suicidal, homicidal, plan):**

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**6. Medical/Medications (physical and behavioral): [include dosage & frequency]**

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**7. Psychosocial Summary (abuse/neglect, cultural, legal, substance abuse):**

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**8. School (grade, special ed, absenteeism, suspension/expulsion):**

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**THERAPEUTIC GROUP CARE  
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**9. Previous treatment:**

Type of Service/Support:	
Date:	
Outcome:	
Type of Service/Support:	
Date:	
Outcome:	
Type of Service/Support:	
Date:	
Outcome:	
Type of Service/Support:	
Date:	
Outcome:	

**10. Current providers and supports:**

Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	

**11. Strengths:**

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**THERAPEUTIC GROUP CARE  
INITIAL REVIEW**

**12. Goals (Behavior-based):**

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**13. Barriers:**

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**14. Discharge plan:**

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**15. Anticipated length of stay:**

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**THERAPEUTIC GROUP CARE  
CONCURRENT REVIEW**

**Client Demographic Information:**

Enrollee Name: \_\_\_\_\_  
Enrollee Medicaid #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Current Provider and  
Level of Care: \_\_\_\_\_  
Address/Phone #: \_\_\_\_\_

**1. Call Demographics:**

Date called to Magellan: \_\_\_\_\_  
Name of Coordinator: \_\_\_\_\_  
Response/review appt  
date and time: \_\_\_\_\_  
Follow up issues: \_\_\_\_\_  
\_\_\_\_\_

**2. Requested Level/Service:**

Provider Name: \_\_\_\_\_  
Address/Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Phone #/Email: \_\_\_\_\_  
Fax #: \_\_\_\_\_  
Requested Begin Date: \_\_\_\_\_

**3. Rationale for continued stay:**

\_\_\_\_\_  
\_\_\_\_\_

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CONCURRENT REVIEW**

**4. Clinical Diagnosis (all five axes):**

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

**5. Risk Assessment (e.g. suicidal, homicidal, plan):**

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**6. Changes in medical/medications (physical and behavioral): [include dosage & frequency]**

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**7. Changes in psychosocial situation (abuse/neglect, cultural, legal, substance abuse):**

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**8. Changes in school (grade, special ed, absenteeism, suspension/expulsion):**

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**THERAPEUTIC GROUP CARE  
CONCURRENT REVIEW**

**9. Changes in current providers and supports (type of service/support, date began):**

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**10. Strengths:**

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**11. Goals (behavior-based):**

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**12. Barriers:**

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**13. Discharge plan:**

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**14. Anticipated discharge date:**

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