

Today's Date \_\_\_\_\_

Hospital: \_\_\_\_\_

Authorization # \_\_\_\_\_

Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Medicaid #: \_\_\_\_\_ Active: Yes \_\_\_ No \_\_\_\_\_

MD's Name: \_\_\_\_\_ Dx: AXIS I: \_\_\_\_\_

M.D. License: \_\_\_\_\_ AXIS II: \_\_\_\_\_

Address: \_\_\_\_\_ AXIS III: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_ AXIS IV: \_\_\_\_\_

Telephone #: \_\_\_\_\_ AXIS V: \_\_\_\_\_

.....  
Date of Last Discharge from your Hospital within last 30 days: \_\_\_\_\_

**Date of Admit:** \_\_\_\_\_ **Time of Admit:** \_\_\_\_\_ am/ pm (circle)

Admission: PEC \_\_\_ Voluntary \_\_\_ Reviewer Name: \_\_\_\_\_ Phone # \_\_\_\_\_

**Reason for Admission:** *(Include clinical signs & symptoms, precipitants. For drug & etoh: amount using, last use, complications)*

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

**Medication Compliant Prior to Admission:** Yes: \_\_\_\_\_ No: \_\_\_\_\_

**Inpatient Treatment Plan:** (Include specific's regarding protocols (ie: medications, type of monitoring))

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

**Locked Unit:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Group Therapy:** \_\_\_\_\_ **Individual Treatment:** \_\_\_\_\_ **Attending Groups:** Yes \_\_\_ No \_\_\_

**Level of Observation:** q15 min \_\_\_ q30 min \_\_\_ qhour \_\_\_

**Medication(s):** \_\_\_\_\_

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