Behavioral Health Review Sheet - INPATIENT

Member's Name / Last, First	Member's ID / Policy #	Date of Birth	Today's Date

Type of admission: ☐ Inpatient ☐ Residential Date of admission: ___________________
Pink slipped: ☐ Yes ☐ NO Hearing date: ___________ Type of review: ☐ Admission ☐ Concurrent
Facility: _______________________________________ OhioHealthy Provider ID: ______________________
Attending MD: __________________________________ OhioHealthy Provider ID: ______________________
Out of Network ☐ If yes, please provide NPI: ___________________________ Tax ID: ________________
UM Contact: ____________________________ UM Phone: ________________ UM Fax: ________________

Psychiatric diagnoses with ICD-10 codes (Axis I / Axis II): ____
____

Medical issues or concerns: ____
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Pertinent lab value(s) with dates: ____
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Pertinent vital signs, CIWA/COWS scores with dates: ____
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Clinical for medical necessity (include reason for admission, precautions, drug dependence, current withdrawal symptoms, social history, group participation, family therapy, reasons for continued stay): ____
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Current psychiatric/neurologic & significant medical medications (include name & dose, date ordered/changed, last time PRN meds given): ____
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____

Disposition / ELOS: ____
Please submit all relevant clinical information to 330-656-2449 or 1-800-385-7085