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REQUEST FOR CONCURRENT REVIEW

SUBMIT TO MHP AS SCHEDULED

TO: Authorization Services
2000 Embarcadero Cove Suite 400
Oakland, CA 94606
(510) 567-8141 Fax (510) 567-8148

Current Information:

1. **Updates to Diagnosis**_____ ☐ **Addition** ☐ **Discontinued**
2. **Current Impairments, Symptoms, Problems, Risks; Progress and Changes; New Impairments, etc.**
   (If suicidal or homicidal ideation is present, indicate plan, means and intent)

3. **Community Referrals**_____
4. **Changes in Treatment (include changes in medications prescribed on-site or elsewhere)**

5. **Treatment Plan (if new impairment is listed, indicate diagnosis to which impairment is related)**

Quantify & Specify impairment in an important area of life functioning and relate to included diagnosis (e.g.: Housebound and poor grooming due to constant hallucinations)	Imp. Criteria (see key below)	Goals and Objectives	Planned types of intervention services Use one box for each requested intervention; attach extra sheet, if needed. Provide start date if new intervention is requested for authorization. **(SPECIFY SERVICE, CPT CODE FROM ACBHCS RATE SHEET, LENGTH OF SESSION, FREQUENCY AND EXPECTED DURATION OF SERVICES** e.g.: Individual psychotherapy, X9502, 60 min, every week, for 4 months**)**	Intervention Criteria (see key below)
			Approach _____ Service Description CPT Code _____ Length/Time Frequency Duration of treatment	
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Impairment Criteria (must have at least one of the following impairments as a result of the listed mental disorder):

A Significant impairment in an important area of life functioning
B Probability of significant deterioration in an important area of life functioning
C (Under 21 yr.) Probability will not progress developmentally as individually appropriate

Intervention Criteria (expectation is that the proposed INTERVENTION will):

1 Significantly diminish impairment
2 Prevent significant deterioration in an important area of life functioning
3 (Under 21 yr.) Probably allow the child to progress developmentally as individually appropriate

*CLIENT NAME:*_ *DOB:* _____ *SSN:*_

DESIGNATED PAYEE/PROVIDER: _____ *PHONE #*_____

PLEASE SIGN PAGE 2 AND SUBMIT BOTH PAGES OF THE RCR

6. Information From Physician (If client is receiving psychotropic medication at your site, the prescribing physician completes this section.)

Additional aspects of psychiatric presentation

Medication/Medical History (PROVIDE AT FIRST PHYSICIAN SERVICES ONLY)

Past psychiatric medication history (maximum dose, duration, when prescribed, effect, reason if discontinued):

Active medical conditions

Medication allergies and sensitivities

Current medication (COMPLETE EACH TIME)

Psychiatric medication (dose, frequency, duration, target symptoms and response, side effects, compliance, informed consent)

Nonpsychiatric medications (dose, duration, target medical condition)

ADDITIONAL DIAGNOSTIC AND TREATMENT IMPRESSIONS_____

PHYSICIAN NAME SIGNATURE DATE

7. Provide If Closing /Discharging Client From Treatment

Date of termination (Last session)_____Reason for termination_____

Treatment Summary.

Follow-up.

Referrals made.

Referrals recommended.

CLIENT INFORMATION AND TREATMENT PLAN DEVELOPED BY

CLINICIAN NAME DISCIPLINE SIGNATURE DATE

SUPERVISOR'S SIGNATURE IF CLINICIAN IS INTERN DATE

*CLIENT NAME:*_____*DOB:* _____*SSN:*_____

DESIGNATED PAYEE/PROVIDER: _____ *PHONE #*_____

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