



Concurrent Review Guide

Please fax completed review to:

**Optum
Attn: County Funded SNF
(888) 687-2515**

| | |
|-----------------------|--|
| Review Date: | |
| Facility Name: | |
| Doctor's Name: | |
| Client Name: | |
| Client DOB: | |
| Date Admitted: | |

Recommended attachments:

- Recent nursing notes
- Past quarter psychiatrist notes
- Past quarter medical doctor notes
- Recent social worker notes
- Documentation of client participation in groups/ activities
- Labs/ physical health documentation
- Treatment Plan/ Care Plan/ Discharge Plan
- Case Manager Quarterly Review

1. Current diagnoses

| | |
|----------------------------------|--|
| Medical Diagnosis: | |
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| | |
| Psychiatric Diagnosis | |
| | |
| | |

2. Current medications (may attach Medication Administration Record)

| Name | Dosage | When taken | Date started | Reason/ Symptom addressed |
|-------------|---------------|-----------------------|-------------------------|----------------------------------|
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3. PRN medications administered

| Name | Dosage | Times taken per month | Date started | Reason/Symptom addressed |
|------|--------|-----------------------|--------------|--------------------------|
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4. High risk behaviors

| Behavior Type | Number of Incidents since last review | Intervention applied and client response |
|-----------------------------|---------------------------------------|--|
| Assault | | |
| Property Destruction | | |
| Threats | | |
| AWOL behavior | | |
| Sexual acting out | | |
| Use of seclusion | | |
| Use of restraints | | |
| Other | | |



5. High risk medical issues/ exacerbations of chronic medical issues

| Medical disorder | Number and type of incidents since last review | Intervention applied and client response |
|------------------|--|--|
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| | | |
| | | |

6. Completion of ADLS/ showers/ bathing/ clothing/ meals

| Behavior | With or without assistance | Average completion per week |
|----------------------------|----------------------------|-----------------------------|
| ADLS | | |
| Showers/Bathing | | |
| Clean appropriate clothing | | |
| Meals | | |

7. Participation in program activities/ groups

| Activity | Average number of times per week | Participation level |
|----------|----------------------------------|---------------------|
| | | |
| | | |
| | | |
| | | |



8. Current discharge planning

**9. Rationale for continued authorization for County Funded SNF level of care
(Include summary of current psychiatric symptoms/ behaviors and barriers to discharge)**