



Concurrent Review Guide for Skilled Nursing Facilities

Please fax completed review to Optum at (888) 687-2515. Thank you.

Review Date	
Facility Name	
Client Name	
Client Date of Birth	
Treating Psychiatrist	
Date Admitted	

Required attachments:

- **Monthly psychiatrist notes for period being reviewed**
- **Updated Care Plan for psychiatric symptoms/behaviors including progress towards goals this quarter**
- **Medication List, including PRNs administered**

Helpful attachments:

- Nursing and social work notes for period being reviewed

1. Current Diagnoses	ICD-Code

2. High Risk Behaviors During Review Period

Behavior Type	Number of Incidents	Date(s) of Incident(s)	Situation, Intervention Applied, and Client Response
Assault/Threats			
Property Destruction			
AWOL			
Substance Use			

Sexual Acting Out			
Use of Seclusion			
Use of Restraints			
Self-Injurious			
Suicide Risk			
Other			

3. Medical Issues, Including Exacerbation of Chronic Medical Issues

Medical Issue	Number of Incidents Since Last Review	Type of Incidents Since Last Review	Intervention Applied and Client's Response

4. Completion of ADLs (Hygiene, bathing, clothing, meals)

Ambulation	<input type="checkbox"/> With Assistance <input type="checkbox"/> Without Assistance	Average Completion per Week:
Showers/Bathing	<input type="checkbox"/> With Assistance <input type="checkbox"/> Without Assistance	Average Completion per Week:
Clean, Appropriate Clothing	<input type="checkbox"/> With Assistance <input type="checkbox"/> Without Assistance	Average Completion per Week:
Meals	<input type="checkbox"/> With Assistance <input type="checkbox"/> Without Assistance	Average Completion per Week:

5. Participation in Program Activities and Groups

Mental Health Groups	Average numbers of groups attended per week:
Actively Participating?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check Topics of Groups Attended	<input type="checkbox"/> Psychiatric symptom management <input type="checkbox"/> Improved cognitive, behavioral, and interpersonal coping <input type="checkbox"/> Substance use recovery groups focused on abstinence, coping skills, and relapse prevention skills <input type="checkbox"/> Other:
Recreational Groups	Average number of groups attended per week:
Actively Participating?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check Topics of Groups Attended	<input type="checkbox"/> Re-training in activities of daily living and social skills

	<input type="checkbox"/> Preparation for re-entry into the mainstream community <input type="checkbox"/> Social and dining <input type="checkbox"/> Information regarding vocational training opportunities, as appropriate <input type="checkbox"/> Money management <input type="checkbox"/> Facility supervised outings <input type="checkbox"/> Other:
Comments	

6. Client's Presentation and Progress

Mental Status Exam Completed on this Date	
Consciousness	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Somnolent <input type="checkbox"/> Stuporous <input type="checkbox"/> Other:
Orientation	<input type="checkbox"/> Intact <input type="checkbox"/> Impaired
Appearance	<input type="checkbox"/> Neat <input type="checkbox"/> Casual <input type="checkbox"/> Unkempt <input type="checkbox"/> Odoriferous <input type="checkbox"/> Other:
Attitude	<input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Guarded <input type="checkbox"/> Other:
Attention/Concentration	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Psychomotor	<input type="checkbox"/> Normal <input type="checkbox"/> Slowed <input type="checkbox"/> Activated <input type="checkbox"/> Agitated <input type="checkbox"/> Involuntary Movements
Eye Contact	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Speech	<input type="checkbox"/> Normal <input type="checkbox"/> Pressured <input type="checkbox"/> Rapid <input type="checkbox"/> Loud <input type="checkbox"/> Slowed <input type="checkbox"/> Soft <input type="checkbox"/> Paucity <input type="checkbox"/> Mute <input type="checkbox"/> Slurred <input type="checkbox"/> Other:
Mood	<input type="checkbox"/> Euthymic <input type="checkbox"/> Depressed <input type="checkbox"/> Elevated <input type="checkbox"/> Anxious <input type="checkbox"/> Irritable <input type="checkbox"/> Other:
Affect	<input type="checkbox"/> Appropriate/Full <input type="checkbox"/> Blunted/Flat <input type="checkbox"/> Constricted <input type="checkbox"/> Inappropriate <input type="checkbox"/> Other:
Memory	<input type="checkbox"/> Intact <input type="checkbox"/> Impaired
Intelligence	<input type="checkbox"/> Average <input type="checkbox"/> High <input type="checkbox"/> Borderline <input type="checkbox"/> Low
Thought	<input type="checkbox"/> Logical <input type="checkbox"/> Goal-directed <input type="checkbox"/> Concrete <input type="checkbox"/> Circumstantial <input type="checkbox"/> Tangential <input type="checkbox"/> Poverty <input type="checkbox"/> Loose Associations <input type="checkbox"/> Blocking <input type="checkbox"/> Slow <input type="checkbox"/> Paranoid Ideation <input type="checkbox"/> Grandiosity <input type="checkbox"/> Delusions <input type="checkbox"/> Other:
Perception	<input type="checkbox"/> Normal <input type="checkbox"/> Hallucinations <input type="checkbox"/> Ideas of Reference:
Insight/Judgement	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Suicidal Ideations	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Means

Homicidal Ideations	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Means
Summary of client's progress and individual interventions utilized	

7. Discharge Planning

Check what occurred during this review period	<input type="checkbox"/> Linkage to community-based organization <input type="checkbox"/> Updated Care Plan <input type="checkbox"/> Improvement shown as documented in their Care Plan <input type="checkbox"/> Improved functional behavior <input type="checkbox"/> Stabilization of medication <input type="checkbox"/> Reduced medication levels, as appropriate <input type="checkbox"/> Stabilization from acute psychiatric symptoms <input type="checkbox"/> Reduction of psychiatric symptoms or concerns <input type="checkbox"/> Collaboration with case manager <input type="checkbox"/> Benefiting from psychosocial programming
Please add any additional comments	

8. Justification for Continued Stay/Barriers to Discharge

Check what occurred during this review period	<input type="checkbox"/> Medication refusals <input type="checkbox"/> Need for psychiatric PRNs <input type="checkbox"/> Aggression/Agitation <input type="checkbox"/> Ongoing paranoia/Delusional thought content <input type="checkbox"/> Ongoing depression/SI <input type="checkbox"/> Impaired ability to attend to ADLs due to psychiatric illness <input type="checkbox"/> Poor insight and judgment
Please describe including additional staff support needed	