Stay Review Justification

Client Name		Admission Date	
Client ID Number			

Describe client's progress in treatment during the past six months (please be detailed and descriptive):

List and explain medical/psychological reasons to continue client's treatment:

Explain the consequences of discontinuing client's treatment:

Stay Review Justification

Client Name		Admission Date	
Client ID Number			

Target date for client to complete treatment:	

What is expected to be achieved during continued treatment (MUST include client's prognosis):

Client's Prognosis: ☐ Good ☐ Fair ☐ Poor (please also elaborate below)

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Counselor or LPHA Name (printed):			
Counselor or LPHA Signature:		Date:	

Below to be completed by an LPHA or Medical Director:

☐ **CONTINUED SERVICES ARE MEDICALLY NECESSARY AND THE FOLLOWING HAVE BEEN CONSIDERED**:

- ☐ The client's personal, medical, and substance use history
- ☐ Documentation of the client's most recent physical examination
- ☐ The client's progress notes and treatment plan goals
- ☐ The LPHA or counselor's recommendation
- ☐ The client's prognosis

☐ **CONTINUING SERVICES FOR THE CLIENT IS NOT MEDICALLY NECESSARY, THE CLIENT MUST BE DISCHARGED FROM TREATMENT* AND ARRANGEMENTS SHALL BE MADE TO APPROPRIATE LEVEL OF TREATMENT SERVICES (IF APPLICABLE).**

*For clients where a justice override applies, please refer to instructions.

LPHA or MD Name (printed):			
LPHA or MD Signature:		Date:	