

**HARMONY HEALTHCARE
CONCURRENT REVIEW FORM**

Patient Name: _____ **Date of Birth:** _____

Address: _____

Family Contact: _____

Social Security No.: _____ **Insurance:** _____

Insurance Identification Number: _____

Updated Diagnoses:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF: _____

Clinical status since last review (Please circle):

Unchanged

Worse

Improved

Explanation:

Currently dangerous to self or others: Yes/No Explain:

Currently unable to care for self: Yes/No Explain:

Medication changes since last review:

Please explain the rationale (medical necessity) for the treatment to continue in an inpatient versus an outpatient setting:

Projected discharge date: _____

Attending doctor: _____

After care plan:

Important: This form must be filled out completely and the clinical information contained herein must be clear and concrete. It must be received by Harmony Healthcare before 11:00 AM of the last approved day and it must convey pertinent observations gathered during the 24 hours preceding its submission. Receipt of the completed form by Harmony Healthcare does not constitute guarantee of approval or payment. The fax number is (702) 471-0154.

Signature: _____ **Date:** _____

Printed Name: _____ **Title/Position:** _____