SA CLINICAL REVIEW - *CONFIDENTIAL*

PATIENT INFORMATION

Name	
ID #	
Age	
Marital	
Parent(s)	

PROVIDER INFORMATION

Name	
QualChoice ID #	*(5 digits)*
Location	
Fax	
Phone	

Referral Source: ☐ Self ☐ PCP ☐ EAP ☐ Family ☐ Employer ☐ Court ☐ Specify: _____

Date(s) Evaluation Completed:	
Date PCP communication sent:	
If PCP communication not sent, reason why:	

DIAGNOSTIC SUMMARY

Axis I:		Axis IV:		Axis V: GAF Current	
Axis II:				Highest Past Year:	
Axis III:					

PROPOSED TREATMENT

☐ Detox: Outpatient
☐ Detox: Inpatient
☐ Intensive Outpatient (IOP)
☐ Clinically Managed Residential Treatment
☐ Medically Monitored Inpatient Treatment
☐ Early Intervention
☐ Aftercare
☐ Psychiatric evaluation
☐ Other:

CLINICAL SYNOPSIS I. Substance Use

Substance	Amount	Frequency	Length of Use	Last Use

- Was acute intoxication present at time of assessment? ☐ No ☐ Yes
- Are current signs of withdrawal present: ☐ No ☐ Yes **Describe:**

- Previous Withdrawal history (describe including DT's, seizures or severe symptoms):

II. Physical conditions

- Does the patient have any physical conditions, including recent injuries, pregnancy, or acute or chornic medical illnesses which may affect treatment: ☐ No ☐ Yes **Describe:**

- Is the patient taking medications (prescribed and OTC): ☐ No ☐ Yes **List:**

III. Psychiatric conditions

- Does the patient have any psychiatric conditions? ☐ No ☐ Yes **Describe:**
- Is the patient taking psychiatric medications? ☐ No ☐ Yes **Describe:**

- Does the patient demonstrate a risk to self or others? ☐ No ☐ Yes **Describe:**
- Who is the treating mental healh provider? _____ Was this provider contacted? ☐ No ☐ Yes
- Psychosocial stressors:

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A Ministry of the Sisters of Charity Health System

PATIENT LABEL

IV. Motivation for treatment

☐ Internal distress/self motivated
☐ Is willing to accept treatment
☐ Other:
☐ Actively objecting/feels coerced
☐ Compliant to avoid negative consequences

V. Relapse Potential

- History of Prior treatment? ☐ No ☐ Yes **Describe** (including length of treatment, completion status, and 12 step program involvement):

- What is the longest period of time the patient has maintained sobriety? _____When was this? _____

- Is the patient knowledgeable of relapse coping skills, relapse triggers, impulse control skills, and coping with craving skills? ☐ No ☐ Yes **Describe:**

VI. Environment

- Does the patient have family member/significant other supports? ☐ No ☐ Yes **Describe:**

- Does the patient have other users or mental illness in family members/significant others, which is likely to affect treatment engagement and success? ☐ No ☐ Yes **Describe:**

- Does the patient have any occupational mandates for treatment? ☐ No ☐ Yes **Describe:**

- Does the patient have any legal mandates for treatment? ☐ No ☐ Yes **Describe:**

CLINICAL IMPRESSION:

Treatment Goals/Strategies:

#1

#2

#3

#4

Community Resources to be used to support the patient and family during and after treatment:

I certify that I have personally provided direct treatment to this patient and the above information is accurate to the best of my knowledge.
Provider's Signature/credential: _____ Date: _____

For QualChoice Use Only:
Case Manager Name:
Criteria Met: ☐ Yes Days/Visits Authorized:
☐ No Referred to Level 2 Review, Date:
Date of Review:
Next Review: