

PART 857 PROBLEM GAMBLING OUTPATIENT SERVICES UTILIZATION REVIEW (UR) FORM

TYPE OF UR (CHECK ONE): (A) <input type="checkbox"/> ADMISSION (B) <input type="checkbox"/> RETENTION (C) <input type="checkbox"/> DISCHARGE		
PATIENT NAME:	ID #:	ADMISSION DATE:
CHECK ONE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> SIGNIFICANT OTHER	DATE OF THIS UR:	
(A) ADMISSION		
Does the patient have a diagnosis related to problem gambling that is supported by the Comprehensive Evaluation? <i>(If No, please explain):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have the Admission Criteria been met? <i>(If No, please explain):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>OUTPATIENT SERVICES ► the individual must be committed to addressing their behaviors from gambling ad/or working towards abstinence; or be a significant other who has been adversely affected by another individual's problem or pathological gambling behaviors, as significant others may be treated as patients in their own right and admitted to the gambling service regardless of whether the addicted person is in treatment, and/or they may be treated as part of a family program/service.</p>		
(B) RETENTION		
Does the patient continue to meet retention criteria for continued stay? <i>(If No, please explain):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Summary of Effectiveness and Progress in Treatment:		
Is there documentation to establish continuing progress toward goals in applicable functional areas? <i>(If No, please explain):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are services identified in treatment plan appropriate to patient needs? <i>(If No, please explain):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
If modification is indicated, has plan been modified? <i>(If No, please explain):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are additional services necessary? <i>(If Yes, describe needed services):</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Recommendation Summary regarding continued stay, intensity of service and/or referral:		

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(C) DISCHARGE		
Have the Discharge Criteria been met?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <i>(see case notes for comments and recommendations)</i>
<i>If Yes, is Discharge Plan with referrals complete and appropriate?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No <i>(see case notes for explanation)</i>

Quality Improvement Commentary:

Adverse Determination Commentary:

QHP COMPLETING UTILIZATION REVIEW (Per provider policy -- include name, title, signature and date)	
NAME of Qualified Health Professional	TITLE
SIGNATURE	DATE