State of New York
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

# UTILIZATION PATIENT RECORD NOTATION

| PATIENT'S LAST NAME | FIRST | M.I. |
|---|---|---|
| CONSECUTIVE NO. | | |
| FACILITY | | ADMISSION DATE |

| Medicaid No. | Medicaid Authorization Date | Medicare No. | Medicare Authorization Date |
|---|---|---|---|
| | | | |

| DATE OF NEXT REVIEW (Mo./Day/Yr.) | TYPE OF REVIEW | *Check One in Each Step* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 1st Step | | | | 2nd Step | | | |
| | | Approved | Not Approved | Reviewer's Initials | Mo./Day/Yr. | Approved | Not Approved | Reviewer's Initials | Mo./Day/Yr. |
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| | ICSR Completed [2] | | | | | | | | |
| | SCSR Completed [3] | | | | | | | | |
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2 Initial Continued Stay Review
3 Subsequent Continued Stay Review

"Approved" means found to meet criteria for admission or continued stay.
"Not Approved" means found not to meet criteria for admission or continued stay.

NOTE: Date of next review should be recorded in the first column.

| UTILIZATION PATIENT RECORD NOTATION | Patient Name (Last, First, M.I.) | Consecutive No. |
|---|---|---|
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