



Concurrent Review of Chemical Dependency Treatment

Please complete all sections of this form and fax it to (651) 662-0718. You will be notified of the review outcome.

If you have any questions, please contact provider services at 1-800-365-2735

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Insurance ID #: _____

Admission Date: ____/____/____ Number of additional days requested: _____ Level of Care _____

CD Treatment Plan Review

Summary Progress Toward Treatment Goals

Dimension I: Acute Intoxication/Withdrawal potential Current Severity (0-4): ____

Overview of Concerns: _____

Dimension II: Biomedical Current Severity (0-4): ____

Overview of Concerns: _____

continue to next page

Dimension III: Emotional/Behavioral/Cognitive

Current Severity (0-4): ____

Overview of Concerns: _____

Dimension IV: Readiness to Change

Current Severity (0-4): ____

Overview of Concerns: _____

Dimension V: Relapse Potential

Current Severity (0-4): ____

Overview of Concerns: _____

Dimension VI: Recovery Environment

Current Severity (0-4): ____

Overview of Concerns: _____

Person Completing Form: _____

Facility Name: _____

Phone Number: (____) _____ Fax Number: (____) _____