Western Highlands Network
Utilization Review
Adult Services

To the provider: Please complete this form for all requests for CST and ACTT, attach a copy of the consumer's updated PCP and send to Services Management at WHN.

If PCP is electronic, please check here____

Date: ________ WHN consumer #_______

Consumer: ____________________________ IPRS target pop: _______
Funding Source: ___________
Provider: _________________ Current GAF: _________
_

DIAGNOSIS:
Axis Ia: _____:_____________ Axis Ib: _____:________
Axis IIa: _____:____________ Axis IIb:_____:________
Axis III:_____:_____________ Additional:_____:_______

Complete the following for all requests:

Current Service: CST____ ACTT____ ACTT date of admission: _____________

Date of last Psychiatric Hospitalization: _________ Location: ____________

Number of Hospitalizations in the last year: _____ Avg. # of face to face contacts Per month in past 3 months _____

Current living situation:
(Please specify type of residence
& who consumer lives with) ____

Number of ES contacts in last month: ______ ER visits in last month: _______ Arrests in last month: __________

Report current involvement of natural supports (family, friends, church, general medical provider, other)

Give general description of the consumer's current status, changes since the last UR period in the consumer's environment, behavior, symptoms, current needs and attempts to step down to a less restrictive service:

____________________________________ ______________________________

Qualified Professional signature / date Supervisor signature /date