

REAUTHORIZATION FOR CONTINUED STAY

| SECTION 1- To be completed by Community Hospitals for Psychiatric Unit Bed Days | | |
|--|--|---------------------------|
| Date this form submitted: / / | Patient Name: | WHN # : |
| Date of Birth: / / | Date Current Authorization Expires: / / | Date of Admission: / / |
| Reauthorization Dates Requested: → | From (date): / / | To (date): / / |

Clinical Justification:

Community Hospital Attending Physician: RATIONAL FOR CONTINUED STAY (Check all that apply)

1. Stabilization and Initial Treatment:

- Recipient has achieved initial stabilization and additional stabilization is indicated
- Recipient is making satisfactory progress toward stabilization, but more time is needed
- Recipient is making some progress but is not yet stable, and treatment plan needs modification so that greater gains, which are consistent with pre-morbid functioning are possible
- Recipient is not making progress. Significant modification of treatment plan needed
- Recipient is regressing

2. Patient cannot be safely discharged as evidenced by

- Inability to manage medical illness with available dispositions
- No disposition has been found to meet patient's needs
- Care Management assistance needed from WHN

DSM-IV Diagnosis: Axis I _____
 Axis II _____
 Axis III _____

Current Medications: _____

(Print) / / /

 Attending Physician Signature /Date

 Verbal Order (VO) Physician Date/Contact

/ /

 Contact Name (Print) / Contact Number
 (May be UR staff for some hospitals)

 Contact Signature

 Contact Email Address

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