

**DEPARTMENT OF MENTAL HEALTH
AMD/SP CLINICAL REVIEW**

CLIENT NAME: _____

LOG #: _____

DOB: _____

AGE: _____

TYPE OF REVIEW:

ELECTIVE: COMPLETE SECTION I & II (OR SECTION III FOR CASE CLOSURE)

SITE REQUEST (REASON)

CRITICAL INCIDENT REVIEW
(INCIDENT #, CRITICAL INCIDENT, DATE, & DESCRIPTION)

MANDATORY:

IFRA REVIEW PRE-DISCHARGE (SECTION I & II & ATTACH IFRA)

SORB LEVEL II-III (OR PENDING) PRE-DISCHARGE (SECTION I, II & ATTACH MIPS/IFRA)

HIGH RISK CLIENT PRE-DISCHARGE FROM FACILITY (SECTION I & II)

UNEXPECTED CLIENT DEATH (ATTACH DECEASED CLIENT PROFILE) (SECTION IV)

SUICIDE ATTEMPT SERIOUS PER AMD (SECTION I & II)

CRITICAL INCIDENT RESULTING IN IFRA LEVEL CHARGE (SECTION I & II)

CURRENT SERVICES: _____

REPORT OF CLINICAL REVIEW

The clinical review was held on _____
Date

Attendance (name and title):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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SECTION I

CLIENT NAME: _____

LOG #: _____

CASE MANAGER: _____

CBFS PROVIDER: _____

GUARDIAN (IF APPLICABLE): _____

DIAGNOSES: _____

MEDICATION:

ATTACHED

MENTAL STATUS

MSE: _____

BEHAVIORS: _____

SOCIAL/FUNCTIONAL: _____

MITIGATING RISK FACTORS: _____

REASON FOR REVIEW/QUESTIONS TO ADDRESS:

RELEVANT HISTORY:

BRIEF SUMMARY INCLUDING HOW LONG INDIVIDUAL HAS BEEN A DMH CLIENT, HISTORY OF HOSPITALIZATION, FAMILY INVOLVEMENT, DIFFERENTIAL DX {IF ANY}, MEDICAL FACTORS) HAVE THERE BEEN SIMILAR INCIDENTS PREVIOUSLY?

NO

YES (IF YES, INCLUDE SUMMARY IN CLIENT HISTORY)

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SECTION II

CLIENT NAME: _____

LOG #: _____

SUMMARY OF DISCUSSION:

RECOMMENDATIONS FROM REVIEW:
(INCLUDE PERSON(S) RESPONSIBLE FOR FOLLOW-UP TASKS)

AMD/SP SIGN OFF:
ADDITIONAL ACTIONS NEEDED NO YES (DESCRIBE)

AMD/SP (OR DESIGNEE) SIGNATURE:

DATE _____

Signature

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SECTION III

REQUEST TO CLOSE TO DMH SERVICES

CLIENT NAME: _____

LOG #: _____

DESCRIBE WHY CLIENT IS CONSIDERED HIGH RISK AND THE RESASON FOR THE REQUEST. DESCRIBE EFFORTS TO RE-ENGAGE IF APPLICABLE.

ACTIVE PROBATE ROGERS? NO YES

ON-GOING NON-DMH SERVICES PERSON WOULD RECEIVE:

INTENT TO CLOSE WAS DISCUSSED WITH: (CONSIDER TREATING PSYCHIATRIST, FAMILY MEMBERS, THERAPIST, ETC.)

DISCUSSION:

RECOMMENDATIONS:

APPROVED FOR CLOSURE

FURTHER ACTION NEEDED PRIOR TO CLOSURE (INCLUDE PERSONS RESPONSIBLE FOR FOLLOW UP TASKS):
SPECIFY:

AMD/SP (OR DESIGNEE) SIGNATURE:

DATE _____

Signature

**DEPARTMENT OF MENTAL HEALTH
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SECTION IV

CLIENT DEATH

CLIENT NAME: _____

LOG #: _____

TYPE OF DEATH: CHOOSE ONE

DCP REVIEWED

CAUSE OF DEATH PENDING

FINAL CAUSE OF DEATH RECEIVED

CAUSE OF DEATH: _____

MANNER OF DEATH: _____

AFTER AMD/SP REVIEW, NO FURTHER REVIEW REQUIRED

SCHEDULE FULL CLINICAL REVIEW

DEATH REVIEW HELD ON:

(COMPLETE SECTION II TO DOCUMENT)

AMD/SP (OR DESIGNEE) SIGNATURE:

DATE _____

Signature