REVIEW PROCESS INFORMATION SHEET
of PSYCHIATRIC INITIAL & FOLLOW-UP EVALUATIONS

To be completed by evaluator:

I Patient Name: _____
Name of Facility: _____
Date of Evaluation: _____

II. Name of Evaluator: _____
Completed Name of Contracted Agency: _____
Address: _____
Phone: _____ Fax: _____

III. If Preadmission Evaluation:
Name of CNC/SW: _____
Address: _____
Phone: _____ Fax: _____

To be completed by reviewing psychiatrist:

IV. Date of psychiatric review: _____
Signature: _____

Comments: ☐ To Evaluator ☐ To DSHS/MHD

_____

To be completed by Quality Assurance Reviewer for DSHS/MHD:

V. Date of QA Review: _____
Signature: _____

Comments: ☐ To Evaluator ☐ To DSHS/MHD

_____

☐ Payment approved – Evaluation complete ☐ Payment denied – Explanation:

_____

Revised Sept. 26, 1997