**360care**

**Behavioral Health Services**
**ASSESSMENT OF MEDICAL NECESSITY by Facility**

**Seven Hills Office Branch**

**Facility Name:** _____ **Date:** _____

I request a mental health and/or psychiatric evaluation and services. Please include the results of the evaluation in the patient's medical record at the location for my review. Based on my professional opinion, this request is medically necessary based on the following: (check all that apply)

**Check all that apply, have Primary Care Physician SIGN and RETURN TO 360CARE**

| | Depressive Sxs | | | | | | | | | | | | Bipolar Sxs | | | | Anxiety Sxs | | | | | | Psychotic Sxs | | | | | Other Sxs | | | | | | | PCP MUST INDICATE | | Internal Use Only |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Resident Name** | Depressive Disorder | Persistent Sadness | Complex Greif | Persistent Irritability/Agitation | Depressive Fatigue | Significant Appetite Change | Depressive Apathy/Inactivity | Frequent Tearfulness | Hopelessness | Talk of Death | Suicidal Ideas | Suicidal Gestures | Bipolar Disorder | Frequent Mood Swings | Hyperactivity | Euphoria | Anxiety Disorder | Chronic Nervousness | Excessive Worry | Unrealistic Fears | Obsessive Thoughts | Compulsive Behaviors | Psychosis | Auditory Hallucinations | Visual Hallucinations | Paranoia | Delusional Thinking | Sleep Disturbance | Combativeness | Affective Disturbance | Attention Deficit | Sexual Acting Out | | | **YES** | **NO** | 360 Chart # |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Primary Care Physician Name (or NP/PA-C) - Printed**

**PRIMARY CARE PHYSICIAN (or NP/PA-C) SIGNATURE**

signature

**Date**

***"YES" MUST be indicated above for a valid order.***

**FAX:** (844) 779-2439 **EMAIL:** branch_sevenhills@360care.com **PHONE:** (844) 779-2433