

EMPLOYEE RESOURCE SYSTEMS, INC.
CONCURRENT REVIEW FORM

Date _____ ERS Case Manager _____

Client Name _____ DOB _____

Provider Name _____ FEIN/SS# _____

Address _____ City _____

State _____ ZIP _____ Phone _____ FAX _____

DSM IV Multiaxial Diagnosis

Axis I	
Axis II	
Axis III	
Axis IV	
Axis V – Current GAF	
Highest GAF in past year	

Risk assessment/Safety plan (0=no risk, 1= mild, 2=moderate risk, 3=extreme risk) _____

Plan _____

Under a physician's care? Yes No

For _____

Current medications: List all psychotropic and prescription medications

Start/dosage _____

Current Signs and Symptoms

0 = None

1 = Mild (Impacts quality of life but no significant impairment of day-to-day functioning.)

2 = Moderate (Significant impact on quality of life and/or day-to-day functioning.)

3 = Severe (Profound impact on quality of life **AND** day-to-day functioning.)

Depressed Mood	0 1 2 3	Irritability	0 1 2 3	Tangential	0 1 2 3
Appetite Disturbance	0 1 2 3	Anxiety	0 1 2 3	Loose Assoc.	0 1 2 3
Sleep Disturbance	0 1 2 3	Panic Attacks	0 1 2 3	Delusions	0 1 2 3
Low Energy/Fatigue	0 1 2 3	Phobias	0 1 2 3	Hallucinations	0 1 2 3
Psychomotor Retardation	0 1 2 3	OCD	0 1 2 3	Aggressive	0 1 2 3
Poor Concentration	0 1 2 3	Eating Disorder	0 1 2 3	Conduct Dis.	0 1 2 3
Agitation	0 1 2 3	Paranoia	0 1 2 3	ADHD	0 1 2 3
Lability	0 1 2 3	Sex Dysfunction	0 1 2 3	Other _____	



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Client _____

Chemical Abuse/Dependency

History: Yes No Current Use: Yes No

Substances _____

Frequency/Amount _____

Length of use _____

Prior Treatment _____

Treatment Goals/Termination Criteria (choose two)

Progress to Date:

Has the client's functioning _____ decreased _____ stayed the same _____ improved?

Has this client been compliant with treatment recommendations? If not, please explain.

Projected Termination Date _____

Concurrent Authorization Request

Date of Initial Session with client _____

How many times have you seen the client to date? _____

How frequently is the client being seen? _____

of Sessions Requested _____ Beginning _____ Ending _____

_____ Date _____

Provider signature

QUESTIONS? CALL THE TOLL-FREE ERS PROVIDER LINE: 866-377-5550

For ERS use only: Date received _____ Date reviewed _____

sessions authorized _____ Authorization # _____ Expires _____

Case Manager _____



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