Date of Form Submission:

TEAM Wellness at Work

Notification Review for New Inpatient Mental Health Services

This request is to only be used for **NEW INPATIENT MENTAL HEALTH SERVICES** for a client. To request additional inpatient services, please complete the "**Notification Review for Additional Inpatient Services**" form found at www.team-mn.com.

Client Information

Client's Name

Client's Date of Birth

Client's Address

Client's Phone #

Group #

ID #

Policy Holder's Name

Admission Diagnoses:

Admission Date

List All Psychotropic Medication(s) & Dosage(s)

Client Presented to Hospital:

☐ On Own ☐ By Police/Ambulance
☐ Transferred from Another Hospital
☐ With Family/Friend

Client is:

☐ Voluntary ☐ On 72 Hour Hold
☐ Suicidal ☐ Homicidal
☐ Delusional ☐ Hallucinating

Provider Information

Name of Hospital/Clinic/Organization

Attending Doctor

Hospital/Clinic/Organization Address

Name of Requestor

Requestor's Phone #

Additional Comments:

Requestor's Email Address & Fax #

Submit completed forms via email or fax to TEAM

TEAM Corporation
Roseville Office Plaza, 1970 Oakcrest Avenue - Suite 200, Roseville, MN 55113
Duluth Labor Temple, 2002 London Road - Suite 95, Duluth, MN 55812
team@team-mn.com
Main: 651.642.0182 | Duluth: 218.727.8589 | Toll Free: 800.634.7710 | Fax: 651.642.1809