

Today's date: \_\_\_\_\_

Date of Admission/Service Start: \_\_\_\_\_

<b>Type of Review:</b>	<input type="checkbox"/> Precertification	<input type="checkbox"/> Continued Stay	<input type="checkbox"/> Discharge	<b>Estimated Length of Stay:</b> _____ (days/units)
<b>Type of Admission:</b>	<input type="checkbox"/> IOP	<input type="checkbox"/> MH-IP	<input type="checkbox"/> PHP/Day Treatment	<input type="checkbox"/> Substance Abuse Rehab <input type="checkbox"/> Substance Abuse Detox
<b>Admission Status:</b>	<input type="checkbox"/> Voluntary	<input type="checkbox"/> Involuntary Commitment	<b>Re-admission within 30 days?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Member Information**

Last, First, MI: \_\_\_\_\_ DOB: \_\_\_\_\_

Member's Address: \_\_\_\_\_ Eligibility ID: \_\_\_\_\_

Emergency Contact (Other than Primary Caregiver): \_\_\_\_\_ Phone: \_\_\_\_\_  
 Legal Guardian/Parent: \_\_\_\_\_ Phone: \_\_\_\_\_

**Provider information**

Facility/Provider Name: \_\_\_\_\_ NPI/Tax ID: \_\_\_\_\_ Provider ID: \_\_\_\_\_

Facility/Provider Address: \_\_\_\_\_ Attending MD: \_\_\_\_\_

UM Review contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

**DSM-5 Diagnoses** (include mental health, substance abuse & medical): \_\_\_\_\_

<b>Medications</b>				
<b>Med Name</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Date of last</b>	<b>Type of Change</b>
				<input type="checkbox"/> Increase; <input type="checkbox"/> Decrease; <input type="checkbox"/> D/C; <input type="checkbox"/> New
				<input type="checkbox"/> Increase; <input type="checkbox"/> Decrease; <input type="checkbox"/> D/C; <input type="checkbox"/> New
				<input type="checkbox"/> Increase; <input type="checkbox"/> Decrease; <input type="checkbox"/> D/C; <input type="checkbox"/> New
				<input type="checkbox"/> Increase; <input type="checkbox"/> Decrease; <input type="checkbox"/> D/C; <input type="checkbox"/> New
				<input type="checkbox"/> Increase; <input type="checkbox"/> Decrease; <input type="checkbox"/> D/C; <input type="checkbox"/> New

**Additional Information:** \_\_\_\_\_

**Presenting Problem/Current Clinical Update: SI, HI, psychotic, mood/affect, sleep, appetite, withdrawal symptoms, chronic SA:**

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**Treatment History and Current Treatment Participation:**

Previous MH/SA Inpatient, Rehab, Detox: \_\_\_\_\_

Outpatient Treatment History: \_\_\_\_\_

Is the member attending therapy and groups?  Yes  No

Explain clinical treatment plan: \_\_\_\_\_

Family involvement/Support system: \_\_\_\_\_

**Substance Abuse:**  Yes  No If yes, MH services only please explain how substance abuse is being treated? \_\_\_\_\_

**Please complete below for current ASAM dimensions and/or submit with documentation for SA IOP, PHP/Day Treatment, SA Detox & SA Rehab**

Dimension Rating (0-4)	<b>Current ASAM Dimensions are Required</b>			
<b>Dimension 1: Acute Intoxication and/or Withdrawal Potential</b>	Substances Used (pattern, route, last used):	Tox Screen Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Results:	History of withdrawal Symptoms:	Current Withdrawal Symptoms:
Rating:				
<b>Dimension 2: Biomedical Conditions &amp; Complications</b>	Vital Signs:	Is member under doctor care? <input type="checkbox"/> Yes <input type="checkbox"/> No Current medical conditions:	History of seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rating:				
<b>Dimension 3: Emotional, Behavioral or Cognitive Conditions &amp; Complications</b>	MH Diagnosis:	Cognitive Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Psych Medications and Dosages:	Current Risk Factors (SI, HI, Psychotic Symptoms, Etc...):
Rating:				
<b>Dimension 4: Readiness to Change</b>	Awareness/commitment to change:	Internal or External Motivation:	Stage of change, if known:	Legal problems/probation officer:
Rating:				
<b>Dimension 5: Relapse, Continued Use or Continued Problem Potential</b>	Relapse Prevention Skills:	Current assessed relapse risk level: <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low	Longest period of sobriety:	
Rating:				
<b>Dimension 6: Recovery/Living Environment</b>	Living Situation:	Sober Support System:	Attendance at support group:	Issues that impede recovery:
Rating:				

**Discharge Planning:** Discharge Planner Name & Contact: \_\_\_\_\_

Residence address upon discharge: \_\_\_\_\_

Treatment Setting & Provider upon discharge: \_\_\_\_\_

Has a post discharge 7-day follow up aftercare appointment been scheduled?  Yes  No

If no, please explain: \_\_\_\_\_

If yes please provide treatment provider name, date and time of scheduled follow-up: \_\_\_\_\_

\_\_\_\_\_