SUBSTANCE USE DISORDER CLINICAL REVIEW INFORMATION

Please fax to: Behavioral Health Unit Toll Free: 1.866.616.6255

Today's Date: _____ Information Submitted By:_____

REVIEW TYPE

☐ Initial ☐ Concurrent ☐ Discharge ☐ Level of Care Transfer

MEMBER INFORMATION

Patient's Name: _____

Date of Birth: _____ ID #: _____

Referring Physician: _____ Admitting Physician:_____

PCP: _____

UTILIZATION REVIEW CONTACT

Name: _____ Facility Name: _____

Phone Number: _____ Fax: _____

Date of Review: _____ Admission Date:_____ Time:_____

ADMISSION TYPE

☐ Emergent ☐ Elective ☐ Urgent ☐ Transfer ☐ Outpatient/Office

REQUESTED LEVEL OF CARE:

- ☐ Early Intervention (0.5)
- ☐ Outpatient Services (1)
- ☐ Intensive Outpatient Services (2.1)
- ☐ Partial Hospitalization Services (2.5)
- ☐ Clinically Managed Low-Intensity Residential Services (3.1)
- ☐ Clinically Managed Population-Specific High-Intensity Residential Services (3.3)
- ☐ Clinically Managed High-Intensity Residential Services (3.5)
- ☐ Medically Monitored Intensive Inpatient Services (3.7)
- ☐ Peer Recovery Support Service

ASSESSMENT

Clinical Disorders/Syndromes Diagnosis Code: _____

Personality Disorders/Intellectual Disabilities Diagnosis Code: _____

Suicidal Ideation: ☐ Ideation ☐ Plan ☐ Intent ☐ None

Homicidal Ideation: ☐ Ideation ☐ Plan ☐ Intent ☐ None

ADMISSION CHIEF COMPLAINT

DIMENSION SEVERITY RATING

1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL □ None □ Mild □ Moderate □ Severe □ Very Severe
Summarize (acute/post-acute symptoms, pertinent lab/diagnostic results, etc.):
2: BIOMEDICAL CONDITIONS □ None □ Mild □ Moderate □ Severe □ Very Severe
Summarize (relevant medical/physical issues, sleep, appetite, etc.):
3: EMOTIONAL/BEHAVIORAL CONDITIONS □ None □ Mild □ Moderate □ Severe □ Very Severe
Summarize (acute psychiatric symptoms, psychiatric history, current psychotropic home meds, etc.):
4: READINESS TO CHANGE □ None □ Mild □ Moderate □ Severe □ Very Severe
Summarize (admission circumstances, substance use disorder treatment history, etc.):
5: RELAPSE/CONTINUED USE POTENTIAL □ None □ Mild □ Moderate □ Severe □ Very Severe
Summarize (precipitating factors, triggers, etc.):
6: RECOVERY ENVIRONMENT □ None □ Mild □ Moderate □ Severe □ Very Severe
Summarize (family/support components, educational needs, legal issues, etc.):

INITIAL ORDERS/TREATMENT:
NUMBER OF DAYS OR SESSIONS PER WEEK: _____

ADHERENCE TO PROGRAM/DAYS ATTENDED IN THIS REVIEW PERIOD:

CHANGES IN MEDICATION:

DISCHARGE GOALS:

BARRIERS TO DISCHARGE:

DISCHARGE PLAN:
DISCHARGE DATE: _____ □ ANTICIPATED □ ACTUAL FOLLOW-UP APPOINTMENT SCHEDULED: _____ DISCHARGE ADDRESS: _____ PHONE: _____ NEW LEVEL OF CARE (if applicable): _____