carelon

Requested Start Date for this Request ___/___/___
Treatment Request: **Admit Date:** ___/___/_____
(Note: ECT &/or Psych Testing requires separate precertification)

Level of Care: Inpatient (for contracts where fax is allowed) ☐ *23hr.* ☐ *CSU*
☐ *Partial* ☐ *RTC* ☐ *IOP/SOPS.* ☐ *Group Home* ☐ *Halfway House* ☐ *Other*

Type of Review: ☐ Prospective ☐ Concurrent ☐ Discharge ☐ Retrospective

Type of Care: ☐ Mental Health ☐ Substance Use ☐ Detox

Demographics:

Patient Name: _____ Date of Birth: _____
Patient/Policyholder ID: _____ Tel#: _____
Patient's City/State: _____
Subscriber's Employer/Benefit Plan: _____
Facility: _____ Fac: ID# _____
Fac. Address/City/St: _____
Attending Provider: _____ Tel #: _____
UR Name: _____
UR Phone #: _____ UR Fax#: _____

Symptomatology leading to request/reason for current admission request:

_____
_____
_____
_____
_____

Diagnosis:

Behavioral DX (ICD Code & Description):
1. _____/_____ 2. _____/_____
Medical DX (ICD code & category:
1. _____/_____ 2. _____/_____
Social Elements Impacting DX: 1. _____ 2. _____
Optional Functional Assessment: Tool: _____ Score: _____
Additional Info: _____

- Are there any comorbid medical conditions that impact the treatment of the diagnosed MHSU conditions? ☐ Yes ☐ No ☐ Unknown
- Is the individual receiving appropriate medical care for the comorbid medical conditions? ☐ Yes ☐ No ☐ Unknown

For Information on how to complete this form—please go to https://www.beaconhealthoptions.com/providers/beacon/forms/clinical-forms/

Metabolic Assessment Tool/ BMI calculations

- Current weight: _____ lbs. Height: __ ft. ___ in.
- Waist Circumference in inches: _____
- If BMI is not assessed, please indicate reason for not obtaining: _____

_____

Current Risk: *Risk Level Scale: 0 = none; 1 = mild, ideation only; 2 = moderate, ideation with EITHER plan or history of attempts; 3 = severe, ideation AND plan, with either intent or means; na = not assessed). Circle risk level*

Risk to Self (SI): 0 1 2 3
Risk to Others (HI): 0 1 2 3

Risk Level Scale: 0 = none; 1 = mild 2 = moderate 3 = severe
Substance Use 0 1 2 3 na

Primary Issues/Symptoms Addressed in Treatment
Indicate primary complex(es) pertinent to this request:
☐ Danger to Self ☐ Danger to Others ☐ Psychosis
☐ Child/Adolescent Behavior ☐ Eating Disorder ☐ Neurocognitive
☐ Substance Use ☐ Mood Disorder

Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:

_____
_____
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Patient's Name:_____ **Patient's ID#**_____

Current Psychotropic Medications	Start Date	Date d/c	Dosage, etc.

Please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care:

_____

_____

_____

URINE DRUG SCREEN

- UDS Completed?: ☐Yes ☐No ☐Unknown Date Completed: _____
- Outcome of UDS: ☐Positive ☐Negative ☐Pending
- Positive for (✓ all that apply): ☐ Cannabis ☐ Opiates ☐ Cocaine ☐ Amphetamines ☐ Tricyclic Antidepressants ☐ Phenylpropanolamine ☐ Benzodiazepines ☐ Barbiturates ☐ Methamphetamine ☐ PCP ☐ LSD ☐ Methadone
- Blood Alcohol: _____ N/A

ASAM Dimensions (Required if request is Substance Use related):

1.	Intoxicated/WD Potential	Lo	Med	Hi	4. Readiness to Change	Lo	Med	Hi
2.	Biomedical Conditions	Lo	Med	Hi	5. Relapse Potential	Lo	Med	Hi
3.	Emot/Reh/Cog Conditions	Lo	Med	Hi	6. Recovery Environment	Lo	Med	Hi

Recovery and Resiliency Environment

Please outline the recovery & resiliency environment to support this individual's long term recovery plan:_____

_____

_____

Best Practice Endorsement: I endorse that I follow Best Practice Guidelines for the Primary Behavioral Diagnosis ☐Yes ☐No If No is selected, please clarify reason why not: _____

_____

Discharge Plan: (Discharge planning considerations should include obtaining releases to speak to & coordinate care with provider(s) transitioning to & should be included as a component of the treatment throughout the entire stay. HEDIS measures should be followed.)

- Expected D/C Date if known:___/___/___ Estimated return to work date ___/__/___
- Planned D/C Level of Care: ☐Outpatient ☐Inpatient ☐23 hr ☐CSU ☐RTC ☐Partial ☐IOP/SOP ☐Group Home ☐Halfway House ☐Other: _____
- Planned D/C Residence: ☐Home (Alone or w/Others) ☐Nursing Home/SNF/Asst. Living ☐TRC/Group Home/Halfway House ☐Shelter ☐Correctional Facility ☐Foster Care ☐Respite ☐State Hospital ☐Residential Placement ☐Juvenile Detention ☐Transfer to Medical ☐Transfer to Alternate Psych Facility ☐Other: _____

For Information on how to complete this form—please go to http://www.valueoptions.com/providers/Forms/Clinical/Inpatient_Treatment_Report_Instructions.pdf.

Discharge Information: (to be included upon discharge)

Note: Any adverse incidents must be reported immediately to ValueOptions.

- Actual Discharge Date: ___/___/_____
- Primary Diagnosis: _____
- Discharge Condition: ☐Improved ☐No Change ☐Worse
- Treatment involved the following (check all that apply): ☐Adverse Incident ☐Child Protection ☐EAP ☐Family ☐Legal System ☐OP Provider
- Other Support Systems ☐PCP ☐None ☐Other: _____
- Discharge plans in place: ☐Yes ☐No
- Type of Discharge: ☐Planned or ☐AMA ☐PCP Notified: ☐Yes ☐ No
- Actual Discharge Level of Care: ☐Outpatient ☐Inpatient ☐ 23 hr ☐CSU ☐RTC ☐Partial ☐IOP/SOP ☐Group Home ☐ Halfway House ☐Other: _____
- Actual Discharge Residence: ☐Home (Alone or w/Others) ☐Nursing Home/SNF/Asst. Living ☐TRC/Group Home/Halfway House ☐Shelter ☐Correctional Facility ☐ Foster Care ☐ Respite ☐ State Hospital ☐Residential Placement ☐Juvenile Detention ☐Transfer to Medical ☐Transfer to Alternate Psych Facility ☐Other: _____

Follow Up Contact Information:

- Member/Family Member Name for Follow Up Contact: _____

_____

- Relationship: _____
- Phone #:_____
- Email Address: _____Do not know, explain

_____

After Care Behavioral Health Provider Name: _____

- ☐ Not arranged ☐Do not know
- After Care Provider Tel. #: _____
- Scheduled Appt Date: ___/___/_____
- Type of Appointment: ☐Mental Health ☐Substance Abuse ☐Med Mgmt

Prescribing Physician Name: _____

- ☐Not arranged ☐Do not know
- Prescribing Physician Tel#:_____
- Prescriber Type: ☐PCP ☐Psychiatrist ☐Other Prescriber Type
- Scheduled Appointment Date: ___/___/_____

_____

Signature of Person Completing This Form Date