(Please include a copy of the LOCADTR3 Report with this form)

fax: 844-231-7948
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carelon

SUD 48 HOUR NOTIFICATION and INITIAL TREATMENT PLAN

Patient Information

Patient Name: _____
Date of Birth: __/__/____
Health Plan: _____
Member ID: _____
☐ Commercial ☐ Medicaid/Essential
Date of Admission: __/__/____

Provider/Agency Name: _____
Site Address: _____
Case Manager & Phone #: _____
NPI #: _____
Tax ID: _____
Diagnosis: _____
_____

Detox Initial Treatment Plan

Adhere to OASAS approved detoxification taper/protocol.

- Medication(s) _____
  _____
- Planned Taper Duration: _____
- Initial Discharge Plan
  - ☐ To home ☐ Inpatient
  - ☐ Outpatient ☐ Residential
  - ☐ Other:
- Medical Stabilization:
  Date of Assessment: __/__/____
  Med Orders: _____
  _____
  _____
- Psychiatric stabilization:
  Date of Assessment: __/__/____
  Med Orders: _____
  _____
  _____

Rehab Initial Treatment Plan (check all that apply)

☐ Individual
☐ Group
☐ Family
☐ Skills/Medication to reduce urges/craving
☐ Motivational Interviewing to increase internal commitment
☐ Coping skills building to improve emotional regulation, self-soothing
☐ Facilitate engagement with others – social skills to support recovery
☐ Education about, orientation to, and the opportunity to participate in, relevant selfhelp groups

☐ Assessment and referral services for patients and significant others
☐ HIV and AIDS education, risk assessment, and supportive counseling and referral

Date of Medical consultation: __/__/____
Date of Psychiatric consultation (as needed): __/__/____

Signature _____ Date: __/__/____