

PLEASE PRINT
 Attach additional pages
 if more space is
 needed

HealthChoice/DHMH
Standard Information Required for
Progress Report and Assessment of Continued Stay for
Partial Hospitalization

_____ **Treatment Plan**

Date contact made to MCO: _____ Time: _____ am / pm	MCO Name _____ Contact Name _____	Date confirmation received from MCO: _____ Time: _____ am / pm
---	--------------------------------------	--

Please complete all sections. For confidentiality purposes, please do not write the client's name in the body of the treatment plan. This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42- Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1. Client's First Name Only	2. Client's Date of Birth _____/_____/_____ Mo Day Yr	3. Client's Sex M___ F___	4a. Client's MCO Number
			4b. Client's MA Number
5. Group Number*	6. Client's Address & Phone Number		
7. Clinician's Name (Printed) _____ Clinician's Signature Date		8. Clinic/Program Name, Address & Phone number	
9. MA Provider Number	10. Referral Source	11. Primary Care Physician	12. Date of Last Exam
13a. Client Pregnant? Yes___ No___ 13b. If Yes, Due Date _____		14. OB/GYN: _____ a. Pre Natal Appt Scheduled: _____ b. Pre Natal Appt Completed: _____ c. OB/GYN Knows of Pregnancy? Yes___ No___	
15. Date Present Treatment Began (mo, day, yr)			
16. Diagnosis (Please complete all axes.) Use DSMIV Codes			
AXIS I		AXIS IV	
AXIS II		AXIS V (GAF)	
AXIS III			
17. Reason for Seeking Treatment/Motivation for Treatment			
18. Substance Abuse History			
Drugs of Choice	Last Use	Route	Date Use Began Frequency
Alcohol _____	_____	_____	Toxicology Screen Date Results
Barbiturates _____	_____	_____	_____
Cocaine _____	_____	_____	_____
Opioids _____	_____	_____	_____
Other _____	_____	_____	_____
19a. History of Delirium Tremens Yes___ Last date _____ No___		19b. History of Blackouts Yes___ Last Date _____ No___	
		19c. Alcohol Related Seizures Yes___ Last Date _____ No___	

20. Substance Abuse Treatment History (Last 3 Years)	21. Medical Complications
	Allergies _____ Heart _____
	Amputee _____ Hepatitis _____
	Cirrhosis _____ HIV _____
	Diabetes _____ Hypertension _____

PLEASE PRINT
Attach additional pages
if more space is
needed

HealthChoice/DHMH
Standard Information Required for
Progress Report and Assessment of Continued Stay for
Partial Hospitalization

_____ **Treatment Plan**

	Enlarged Liver _____ Gunshot _____ Head Injury _____ Hearing Impaired _____	Jaundice _____ Seizures _____ STDs _____ Other _____	
22. List All Medications (including Methadone)			
Type	Dosage	Start Date	Response
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
23. If medications are being administered by someone other than yourself, please identify.			_____ _____
24. Suicidal/Homicidal Behaviors? No _____ Yes _____ Clarify _____ If yes, is client able to contract for safety? _____ List recent hospitalization or attempts _____ _____			
25. If client has a co-occurring psychiatric diagnosis, is client in treatment? Yes _____ No _____			
26. Client's Mental Health Professional _____ Phone Number _____ Release of Information Signed? Yes _____ No _____			
27. Psychosocial Functioning: Domestic Violence _____ Drugs in the Home _____ Education _____ Legal Problems _____ Primary Support System _____ Recovery Environment _____ Working _____ Other _____			
28. Brief Mental Status			
29. Assessment Tools MAST Score _____ POSIT Score _____ ASAM Criteria _____ Dimensions: I _____ II _____ III _____ IV _____ V _____ VI _____ Level of Placement Assigned _____			

PLEASE PRINT
Attach additional pages
if more space is
needed

HealthChoice/DHMH
Standard Information Required for
Progress Report and Assessment of Continued Stay for
Partial Hospitalization

____ Treatment Plan

30. Statement of Problem/s

Goals related to Presenting Problems (use finite / measurable / observable terms)**
**12 STEP/Community Support/Spirituality

Short term:

1)

2)

3)

Long term:

1)

2)

3)

Client's Signature

Date

PLEASE PRINT
Attach additional pages
if more space is
needed

HealthChoice/DHMH
Standard Information Required for
Progress Report and Assessment of Continued Stay for
Partial Hospitalization

____ Treatment Plan

Partial Hospitalization
Per ASAM Level II.5 for Adults
Per ASAM Level II for Adolescents

For Scoring Purposes:
Adults must meet one Dimension from Dimensions 4 or 5 or 6.
Adolescents must meet one Dimension from Dimensions 3 or 4 or 5 or 6.
Justify specific behavioral and environmental conditions for level of care.