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HealthChoice/DHMH

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Standard Information Required for Telephonic Authorization for:

- Intermediate Care Facility Treatment
- Acute Inpatient Treatment

Date contact made to MCO: _____ Time: _____ am / pm	MCO Name _____ Contact Name _____	Date confirmation received from MCO: _____ Time: _____ am / pm
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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
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7. Clinician's Name (Printed) _____ Clinician's Signature _____ Date _____	8. Clinic/Program Name, Address & Phone number
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9. MA Provider Number	10. Referral Source	11. Primary Care Physician	12. Date of Last Exam
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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 ___
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15. Date Present Treatment Began (mo, day, yr)
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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
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18. Substance Abuse History			Toxicology Screen			
Drugs of Choice	Last Use	Route	Date Use Began	Frequency	Date	Results
Alcohol _____	_____	_____	_____	_____	_____	_____
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 ___
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20. Substance Abuse Treatment History (Last 3 Years)	21. Medical Complications Allergies _____ Heart _____ Amputee _____ Hepatitis _____
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	Cirrhosis _____	HIV _____
	Diabetes _____	Hypertension _____
	Enlarged Liver _____	Jaundice _____
	Gunshot _____	Seizures _____
	Head Injury _____	STDs _____
	Hearing Impaired _____	Other _____

22. List All Medications (including Methadone/LAAM)

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 \_\_\_\_\_

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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

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<p><b>Intermediate Care Facility</b> Per ASAM Level III</p>
<p>For Scoring Purposes:</p> <p>Client must meet two of six Dimensions.</p> <p>For adolescents, client must meet the specifications in two of six Dimensions.</p> <p>Justify <u>specific</u> behavioral and environmental conditions for ICF-A level of care.</p>

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<p><b>Acute Inpatient Treatment</b> Per ASAM Level IV</p>
<p>For Scoring Purposes: Client must meet at least one Dimension from Dimensions 1 or 2 or 3 .</p> <p>Justify <u>specific</u> behavioral and environmental conditions for level of care.</p>