

Today's date: _____ Date of admission or service start: _____

Type of review		Estimated length of stay
<input type="checkbox"/> Precertification <input type="checkbox"/> Continued stay <input type="checkbox"/> Discharge		(days/units)
Type of admission		
<input type="checkbox"/> Intensive outpatient <input type="checkbox"/> Mental health inpatient <input type="checkbox"/> Partial hospitalization program <input type="checkbox"/> Substance use detox in a hospital setting		
Admission status		Readmission within 30 days
<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary commitment		<input type="checkbox"/> Yes <input type="checkbox"/> No

Member information		
Last, first, middle initial:	Date of birth:	
Address:	Eligibility ID:	
Emergency contact (other than primary caregiver):	Phone:	
Parent, guardian, or legal representative:	Phone:	
Provider information		
Facility or provider name:	NPI or tax ID:	Provider ID:
Address:	Attending M.D.:	
UM Review contact:	Phone:	
DSM-5 diagnoses (include mental health, substance use, and medical):		

Medications				
Medication name	Dosage	Frequency	Date of last	Type of change
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
Additional information:				



Presenting problem or current clinical update

(e.g., suicidal ideation, homicidal ideation, psychotic symptoms, mood/affect, sleep, appetite, withdrawal symptoms, chronic substance use)

Treatment history and current treatment participation

Previous mental health or substance use inpatient, rehab, detox:

Outpatient treatment history:

Is the member attending therapy and groups? Yes No

Explain clinical treatment plan:

Family involvement and support system:

Substance use: Yes No

If yes, for mental health services only, please explain how substance use is being treated.

Please complete below for current American Society of Addiction Medicine (ASAM) dimensions and/or submit with documentation for substance use detox.

Dimension rating (0 – 4)

Current ASAM dimensions are required.

Dimension 1: Acute intoxication and/or withdrawal potential

Rating:

Substances used (pattern, route, last used):

Tox screen completed? Yes No

If yes, results:

History of withdrawal symptoms:

Current withdrawal symptoms:

Dimension 2: Biomedical conditions and complications

Rating:

Vital signs:

Is member under a health care provider's care? Yes No

Current medical conditions:

History of seizures? Yes No



Dimension rating (0 – 4) continued
Current ASAM dimensions are required.

Dimension 3: Emotional, behavioral, or cognitive conditions and complications	Rating:
Mental health diagnosis:	
Cognitive limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Psych medications and dosages:	
Current risk factors (e.g., suicidal ideation, homicidal ideation, psychotic symptoms):	
Dimension 4: Readiness to change	Rating:
Awareness and commitment to change:	
Internal or external motivation:	
Stage of change, if known:	
Legal problems/probation officer:	
Dimension 5: Relapse, continued use, or continued problem potential	Rating:
Relapse prevention skills:	
Current assessed relapse risk level: <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low	
Longest period of sobriety:	
Dimension 6: Recovery and living environment	Rating:
Living situation:	
Sober support system:	
Attendance at support group:	
Issues that impede recovery:	

Discharge planning

Discharge planner name and contact:
Residence address upon discharge:
Treatment setting and provider upon discharge:
Has a post-discharge seven-day follow-up aftercare appointment been scheduled? <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please explain:
If yes, please provide treatment provider name and date and time of scheduled follow-up:

Original 1/1/2023