



**Behavioral Health Authorization Request Form**

Please Fax Completed Form To: 1-888-245-2027

Behavioral Health Department: 1-800-685-5209

Type of request:    Admission                       Continued Stay/Authorization # \_\_\_\_\_

<b>Member Name:</b>	<b>Member ID Number:</b>
<b>Member Phone Number:</b>	<b>Member Date of Birth:</b>
<b>Requesting Facility Name:</b>	<b>Person Completing Form/Phone Number:</b>
<b>Admitting Facility:</b>	<b>Admitting Facility Contact/ Phone Number:</b>
<b>Date/Time of Admission:</b>	<b>Treating Physician:</b>
<b>Commitment Status/Pending Hearings: (if applicable):</b>	<b>Member's Preferred Language:</b>
<b>Substance Use History:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes ( <i>Please Specify Substance of Choice, Amount of Use</i> )	
<b>Details:</b>	
<b>Drug screen results and alcohol level on admit:</b>	
Tobacco Use: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Legal Issues: <input type="checkbox"/> No <input type="checkbox"/> Yes ( <i>please explain</i> ):	

<b>List All Diagnoses (Including Medical Comorbids):</b>

**Member Name:**

<b>Current Symptoms (check all that apply)</b>			
<input type="checkbox"/> <b>Suicidal Ideation</b> <b>Details:</b>			
<input type="checkbox"/> <b>Homicidal Ideation</b> <b>Details:</b>			
<input type="checkbox"/> <b>Psychosis</b> <input type="checkbox"/> <b>Hallucinations</b> <b>Details:</b>  <input type="checkbox"/> <b>Delusions/Paranoia</b> <b>Details:</b>			
<input type="checkbox"/> <b>Self Injurious Behaviors</b> <b>Details:</b>		<input type="checkbox"/> <b>Aggression/Assaultive Behaviors</b> <b>Details:</b>	
<b>Mood:</b> <input type="checkbox"/> <b>Depressed</b> <input type="checkbox"/> <b>Anxious</b> <input type="checkbox"/> <b>Labile</b> <input type="checkbox"/> <b>Elated</b> <input type="checkbox"/> <b>Irritable</b> <input type="checkbox"/> <b>Other:</b>	<b>Affect:</b> <input type="checkbox"/> <b>Euthymic</b> <input type="checkbox"/> <b>Dysphoric</b> <input type="checkbox"/> <b>Congruent</b> <input type="checkbox"/> <b>Labile</b> <input type="checkbox"/> <b>Flat</b> <input type="checkbox"/> <b>Other:</b>	<b>ADLS:</b> <input type="checkbox"/> <b>WNL</b> <input type="checkbox"/> <b>Good</b> <input type="checkbox"/> <b>Fair</b> <input type="checkbox"/> <b>Poor</b> <input type="checkbox"/> <b>Independent</b> <input type="checkbox"/> <b>Other:</b>	<b>Appearance:</b> <input type="checkbox"/> <b>Good</b> <input type="checkbox"/> <b>Fair</b> <input type="checkbox"/> <b>Poor</b> <input type="checkbox"/> <b>Disheveled/Unkempt</b> <input type="checkbox"/> <b>Malodorous</b> <input type="checkbox"/> <b>Other:</b>
<b>Appetite:</b> <input type="checkbox"/> <b>Good</b> <input type="checkbox"/> <b>Fair</b> <input type="checkbox"/> <b>Poor</b>	<b>Eye Contact:</b> <input type="checkbox"/> <b>Good</b> <input type="checkbox"/> <b>Fair</b> <input type="checkbox"/> <b>Poor</b>	<b>Insight:</b> <input type="checkbox"/> <b>Good</b> <input type="checkbox"/> <b>Fair</b> <input type="checkbox"/> <b>Poor</b>	<b>Judgement:</b> <input type="checkbox"/> <b>Good</b> <input type="checkbox"/> <b>Fair</b> <input type="checkbox"/> <b>Poor</b>
<b>Sleep:</b> <input type="checkbox"/> <b>Good</b> <input type="checkbox"/> <b>Fair</b> <input type="checkbox"/> <b>Poor</b>	<b>Cognition:</b> <input type="checkbox"/> <b>Attentive</b> <input type="checkbox"/> <b>Unable to Focus</b> <input type="checkbox"/> <b>Poor Concentration</b>	<b>Speech:</b> <input type="checkbox"/> <b>WNL</b> <input type="checkbox"/> <b>Pressured</b> <input type="checkbox"/> <b>Rapid</b> <input type="checkbox"/> <b>Latency</b> <input type="checkbox"/> <b>Loud</b> <input type="checkbox"/> <b>Impoverished</b>	
<b>Additional Treatment Plan and Orders:</b> <input type="checkbox"/> <b>Suicide Precautions</b> <input type="checkbox"/> <b>1:1 Observations</b> <input type="checkbox"/> <b>Seclusion</b> <input type="checkbox"/> <b>Restraints</b> <input type="checkbox"/> <b>Forced Meds</b> <input type="checkbox"/> <b>Other:</b>		<b>Thought Process/Content:</b> <input type="checkbox"/> <b>WNL</b> <input type="checkbox"/> <b>Tangential</b> <input type="checkbox"/> <b>Goal Directed</b> <input type="checkbox"/> <b>Preoccupied</b> <input type="checkbox"/> <b>Loose Associations</b> <input type="checkbox"/> <b>Bizarre</b> <input type="checkbox"/> <b>Flight of Ideas</b> <input type="checkbox"/> <b>Perseverative</b> <input type="checkbox"/> <b>Thought Blocking</b> <input type="checkbox"/> <b>Circumstantial</b>	
<b>Additional Clinical Information:</b>   			

Member Name:

MEDICATION				<b>**CHANGES SINCE LAST REVIEW</b>	
Medication	Dosage	Route	Frequency	<b>**Medication Changes Since Last Review (N/A on Admits)</b>	<b>**Date of Change (N/A on Admits)</b>
Have PRN's Been Given Since Last Review <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(Please Specify Below)</i>					
Medication	Dosage	Route	Frequency and Dates Given		

Support System				
Does Member Have Family/Informal Supports: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(Please Specify Below)</i>				
List:				
Is There Existing Outpatient Care/Case Manager/ACT Team: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(Please Specify Below)</i>				
Provider Name	Type of Service	Contact Name	Phone Number	Notified
				<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes
Current living situation:				
Is Member Able to Return To This Housing Following Discharge? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Barriers to Treatment:				
Transportation to Appointments:			Pharmacy Name/Phone Number:	

Discharge and Aftercare Plan
<i>(include provider member will be seeing upon discharge from this admission)</i>