



**Substance Use Disorder 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>Tobacco Use:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>Legal Issues:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes ( <i>please explain</i> ):			
<b>Requested ASAM Level of Care:</b>		<b>Drug screen results and alcohol level:</b>			
<b>Withdrawal Scale Scores (WAS/COWS):</b>		<b>Number of Days Requested:</b>			
<b>Member's Preferred Language:</b>					
<b>Vitals</b>					
<b>BP:</b>	<b>Pulse:</b>	<b>Resp:</b>	<b>Temp:</b>		
<b>List All Diagnoses (Including Medical Comorbid)</b>					
<b>Presenting Problem (include member's motivation for treatment)</b>					
<b>ASAM Criteria (specify level of care and risk score)</b>					
<b>DIMENSION I:</b>		<b>DIMENSION II:</b>			
<b>DIMENSION III:</b>					
<b>Substance Use</b>					
<b>Substance Of Abuse</b>	<b>Amount</b>	<b>Frequency</b>	<b>Route</b>	<b>Duration at this Rate</b>	<b>Date Last Used</b>

Member Name:

Current Acute or Post-Acute Withdrawal Symptoms <i>(check all that apply)</i>					
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Tremors	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Irritability	<input type="checkbox"/> Agitation
<input type="checkbox"/> Headache	<input type="checkbox"/> Restlessness	<input type="checkbox"/> Mydriasis	<input type="checkbox"/> Rhinorrhea	<input type="checkbox"/> Lacrimation	<input type="checkbox"/> Yawning
<input type="checkbox"/> Abdominal Cramps	<input type="checkbox"/> Bone/Joint Aches	<input type="checkbox"/> Piloerection	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/> Tactile Disturbance
<input type="checkbox"/> Auditory Disturbance					
<input type="checkbox"/> Other: <i>(Please Specify)</i>					
Prior Substance Use Treatment History <i>(please specify facility, dates, clean time after treatment)</i>					
Treatment Plan and Orders:					
MEDICATION				**DETOX MEDICATIONS	
Medication	Dosage	Route	Frequency	**Date Started <i>(N/A if not detox med)</i>	**Projected End Date <i>(N/A if not detox med)</i>
Does Member Have Family/Informal Supports: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(Please Specify Below)</i>			Is There Existing Outpatient Care: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(Please Specify Below)</i>		
List:			List:		
Current living situation:  Able to Return? <input type="checkbox"/> No <input type="checkbox"/> Yes	Transportation to Appointments:		Pharmacy Name/Phone Number:		
Discharge and Aftercare Plan					
<i>(include provider member will be seeing upon discharge from this admission)</i>					