



INPATIENT TREATMENT REPORT (ITR) - Page One of Two

Requested Start Date for this Authorization ____/____/____

Level of Care: Inpatient 23 hr CSU Partial RTC IOP/SOP
 Group Home Halfway House Other _____

Type of Review: Prospective Concurrent Discharge Retrospective
Type of Care: Mental Health Substance Abuse Detox

Precipitating Event: _____

Patient's Current Location: ER Jail/Detention Facility
 Provider's Office Home/Community

Demographics:

Patient's Name _____ Date of Birth: _____
Patient/Policyholder ID#: _____ Tel #: _____
Patient's City/State: _____
Subscriber's Employer/Benefit Plan: _____
Facility: _____ Fac: ID# _____
Fac. Address/City/St: _____
Attending Provider: _____ Tel #: _____
UR Name: _____
UR Phone #: _____ UR Fax #: _____

DSM-IV Diagnosis:

Axis I 1) _____ 2) _____
Axis II: 1) _____ 2) _____
Axis III: 1) _____ 2) _____
Axis IV: _____
Axis V: Current GAF: _____ Highest GAF prev. year: _____

Current Risks: Risk Level Scale: 0=none, 1-mild, ideation only; 2=moderate, ideation with EITHER plan or history of attempts; 3=severe, ideation AND plan, with either intent or means; na=not assessed. Circle risk level for each category and check all boxes that apply:

Risk to Self (SI): 0 1 2 3 na with ideation intent plan means
Risk to Others (HI): 0 1 2 3 na with ideation intent plan means
Current serious attempts: Yes No Circle SI HI
Prior serious attempts: Yes No Circle SI HI
Prior serious gestures: Yes No Circle SI HI
Date of the most recent attempt or gesture: ____/____/____

Current Impairments: Scale 0=none, 1=mild, 2=moderate, 3=severe, na=not assessed

0 1 2 3 na Mood Disturbance (Depression or mania)
0 1 2 3 na Anxiety
0 1 2 3 na Psychosis
0 1 2 3 na Thinking/Cognition/Memory
0 1 2 3 na Impulsive/Reckless/Aggressive
0 1 2 3 na Activities of Daily Living
0 1 2 3 na Weight Change Assoc. w/Behav Dx ⇨ Gain Loss na of _____
0 1 2 3 na Medical/Physical Condition(s) pounds in last three months
0 1 2 3 na Substance Abuse/Dependent Current weight - _____ lbs na
0 1 2 3 na Job/School Performance Height - _____ft. _____ in. na
0 1 2 3 na Social/Marital/Family Problems
0 1 2 3 na Legal

Mental Health/Psychiatric Treatment History: (Please check all that apply) None Unknown

Outpatient. If "Outpatient" is checked, please indicate:
Outcome: Unknown Improved No Change Worse
Treatment compliance (non-med): Unknown Poor Fair Good
 IOP/Partial. If "IOP/Partial" is checked, please indicate:
Outcome: Unknown Improved No Change Worse
Treatment compliance (non-med): Unknown Poor Fair Good
 Inpatient/Residential/Group Home: If "Inpatient/Residential" is checked, please indicate:
Outcome: Unknown Improved No Change Worse
Treatment compliance (non-med): Unknown Poor Fair Good
Number of psychiatric hospitalizations in the past 12 months: _____

Substance Abuse Treatment History: (Please check all that apply) None Unknown

Outpatient. If "Outpatient" is checked, please indicate:
Outcome: Unknown Improved No Change Worse
Treatment compliance (non-med): Unknown Poor Fair Good
 IOP/Partial. If "IOP/Partial" is checked, please indicate:
Outcome: Unknown Improved No Change Worse
Treatment compliance (non-med): Unknown Poor Fair Good
 Inpatient/Residential/Group Home: If "Inpatient/Residential" is checked, please indicate:
Outcome: Unknown Improved No Change Worse
Treatment compliance (non-med): Unknown Poor Fair Good
Number of substance abuse hospitalizations in the past 12 months" _____

Other Treatment History:

Mandatory workplace referral? Yes No EAP involved: Yes No
EAP Name: _____
Criminal justice involvement in the last 12 months? Yes No
Currently on probation: Yes No
History of sexually inappropriate/aggressive behavior? Yes No
History of fire setting in the last 12 mos? Yes No
Active gang involvement in the last 12 mos? Yes No
DSS/CPS involvement in the last 12 mos? Yes No
Victim of sexual or physical abuse? Yes No

PATIENT'S NAME: _____ PATIENT'S ID# _____

Current Psychotropic Medications: None Dose Freq. Usually adherent?

			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Substance Use/Abuse: No Yes Unknown If yes, please complete below.

Substance	Length Curr. Use	Amount	Freq.	Date Last Used

Withdrawal Symptoms: Check all that apply. None

- Nausea Sweating Tremors Past DTs
- Vomiting Agitation Blackouts Current Seizures
- Cramping Hallucinations Current DTs Past Seizures

Vitals (if Detox or Relevant): BP: ___ Temp: ___ Pulse: ___ Resp: ___ BAL: ___

UDS: Yes No Date: _____ Outcome: Pending Negative Positive

If positive, for what? _____

Longest period of sobriety: <6 mo. 6 mo.-2yrs 2+ yrs None Unknown

Relapse Date: ___/___/___

ASAM Dimensions:

- 1. Intoxicated/WD Potential Lo Med Hi 4. Readiness to Change Lo Med Hi
- 2. Biomedical Conditions Lo Med Hi 5. Relapse Potential Lo Med Hi
- 3. Emot/Beh/Cog Conditions Lo Med Hi 6. Recovery Environment Lo Med Hi

Treatment Request: Admit Date: ___/___/___

(Note well: Each level of care, ECT &/or Psych Testing requires separate precertification)

Is family/couples therapy indicated? Yes No If yes, date of appt. ___/___/___

Involuntary Court Ordered Fixed Length Program (Specify length: _____)

Frequency of program = _____ per _____

Reason for Continued Stay: Remains symptomatic Conduct family therapy

Stabilize medications Has not achieved treatment goals Finalize disch. plan

Other _____

Barriers to Discharge: Discharge treatment setting not available Transportation

Legal Mandate Adequate Housing/Residence Lack of Community Support

Treatment Non-Compliance Other _____

Baseline Functioning: Holds Job Asymptomatic Manages Meds/Med Compliant

Functions Independently/ADLs Satisfactory Abstinent Other _____

Discharge Plan:

Expected D/C Date if known: ___/___/___ Estimated return to work date ___/___/___

Planned D/C Level of Care: Outpatient Inpatient 23 hr CSU RTC Partial

IOP/SOP Group Home Halfway House Other: _____

Planned D/C Residence: Home (Alone or w/Others)

Nursing Home/SNF/Asst. Living RTC/Group Home/Halfway House Shelter

Correctional Facility Foster Care Respite State Hosp. Residential Placemnt.

Juvenile Detention Transfer to Medical Transfer to Alternate Psych. Facility

Other _____

Discharge Information: (to be included upon discharge)

Actual Discharge Date: ___/___/___

Primary Discharge Diagnosis: _____

Discharge GAF: _____ Discharge Condition: Improved No Change Worse

Treatment involved the following (check all that apply): Adverse Incident

Child Protection EAP Family Legal System OP Provider

Other Support Systems PCP None Other: _____

Note: Any adverse incidents must be reported immediately to ValueOptions.

Discharge plans in place? Yes No

Type of Discharge: Planned or AMA PCP Notified Yes No

Actual Discharge Level of Care: Outpatient Inpatient 23 hr CSU

RTC Partial IOP/SOP Group Home Halfway House

Other _____

Actual Discharge Residence: Home (Alone or w/Others)

Nursing Home/SNF/Asst. Living RTC/Group Home/Halfway House Shelter

Correctional Facility Foster Care Respite State Hosp. Residential Placemnt.

Juvenile Detention Transfer to Medical Transfer to Alternate Psych. Facility

Other: _____

Member/Family Member Name for Follow Up: _____

Relationship: _____

Phone #: _____ Do not know

After Care Behavioral Health Provider: Not arranged Do not know

After Care Provider Name: _____

After Care Provider Tel. #: _____

Scheduled Appointment Date: ___/___/___

Type of Appointment: Mental Health Substance Abuse Med Mgmt.

Prescribing Physician: Not arranged Do not know

Prescribing Physician Name: _____

Prescribing Physician Tel #: _____

Prescriber: PCP Psychiatrist Other Prescriber Type

Scheduled Appointment Date: ___/___/___

Signature of Person Completing This Form

Date