



# INPATIENT TREATMENT REPORT (ITR) - Page One of Two

Requested Start Date for this Authorization \_\_\_/\_\_\_/\_\_\_

Level of Care:  Inpatient  23 hr  CSU  Partial  PRTE/RTC  IOP/SOP  
 Residential (II-IV excl. Foster Care)  Foster Care  Community Support Indv.  
 Community Support Group  Community Support Team  
 Other \_\_\_\_\_

Type of Review:  Prospective  Concurrent  Discharge  Retrospective  
 Additional Units for current authorization period

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 \_\_\_\_\_  
pounds in last three months  
0 1 2 3 na Medical/Physical Condition(s) Current weight - \_\_\_\_\_ lbs  na  
0 1 2 3 na Substance Abuse/Dependent Height - \_\_\_\_\_ ft. \_\_\_\_\_ in.  na  
0 1 2 3 na Job/School Performance  
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

Outpatient. If "Outpatient" is checked, please indicate:  Unknown  
Ou tcome:  Unknown  Improved  No Change  Worse  
Treatment compliance (non-med):  Unknown  Poor  Fair  Good  
 IOP/Partial. If "IOP/Partial" is checked, please indicate:  
Ou tcome:  Unknown  Improved  No Change  Worse  
Treatment compliance (non-med):  Unknown  Poor  Fair  Good  
 Inpatient/Residential/Group Home: If "Inpatient/Residential" is checked, please indicate:  
Ou tcome:  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:  
Ou tcome:  Unknown  Improved  No Change  Worse  
Treatment compliance (non-med):  Unknown  Poor  Fair  Good  
 IOP/Partial. If "IOP/Partial" is checked, please indicate:  
Ou tcome:  Unknown  Improved  No Change  Worse  
Treatment compliance (non-med):  Unknown  Poor  Fair  Good  
 Inpatient/Residential/Group Home: If "Inpatient/Residential" is checked, please indicate:  
Ou tcome:  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.

<i>Substance</i>	<i>Length Curr. Use</i>	<i>Amount</i>	<i>Freq.</i>	<i>Date Last Used</i>

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