Behavioral Health Clinical Fax Form

When complete, please fax to 855.301.5356

Today's date: _____ Date of Admission/Service Start: _____

Type of Review:	☐ Precertification	☐ Continued Stay	**Estimated Length of Stay:** _____ (days/units)
Type of Admission:	☐ MH-IP	☐ Substance Abuse Rehab ☐ Substance Abuse Detox ☐ Substance Abuse Halfway House	☐ PHP/Day Treatment ☐SA IOP
Admission Status:	☐ Voluntary	☐ Involuntary Commitment	**Re-admission within 30 days?** ☐ Yes ☐ No

Member Information

Last, First, MI: _____ DOB: _____

Member's Address: _____ Eligibility ID: _____

Emergency Contact (Other than Primary Caregiver): _____ Phone: _____

Legal Guardian/Parent: _____ Phone: _____

Provider information

Facility/Provider Name: _____ NPI/Tax ID: _____ Provider ID: _____

Facility/Provider Address: _____ Attending MD: _____

Subs

UM Review contact: _____ Phone #: _____

DSM-5 Diagnoses (include mental health, substance abuse & medical): _____

For Members age 21 & under: has a Certificate of Need been completed? ☐ Yes ☐ No If yes, please attach to request. If No, please explain: _____

Please note that for all BH IP admissions for members age 21 and under a Certificate of Need (CON) is required to be submitted to AmeriHealth Caritas Louisiana by close of business on the same day a request is submitted.

Medications				
Med Name	***Dosage***	***Frequency***	***Date of last***	***Type of Change***
				☐ Increase; ☐ Decrease; ☐ D/C; ☐ New
				☐ Increase; ☐ Decrease; ☐ D/C; ☐ New
				☐ Increase; ☐ Decrease; ☐ D/C; ☐ New
Additional Information:				

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Presenting Problem/Current Clinical Update: SI, HI, psychotic, mood/affect, sleep, appetite, withdrawal symptoms, chronic SA:

_____

_____

_____

_____

_____

_____

Treatment History and Current Treatment Participation:

Previous MH/SA Inpatient, Rehab, Detox: _____

Outpatient Treatment History: _____

Is the member attending therapy and groups? ☐ Yes ☐ No
Explain clinical treatment plan: _____

Family involvement/Support system: _____

Substance Abuse: ☐ ***Yes*** ☐ ***No*** **If yes, MH services only please explain how substance abuse is being treated?** _____

_____

Please complete below for current ASAM dimensions and/or submit with documentation for SA IOP, PHP/Day Treatment, SA Detox & SA Rehab

Dimension Rating (0-4)	***Current ASAM Dimensions are Required***			
Dimension 1: Acute Intoxication and/or Withdrawal Potential	Substances Used (pattern, route, last used):	Tox Screen Completed? ☐ Yes ☐ No If Yes, Results:	History of withdrawal Symptoms:	Current Withdrawal Symptoms:
Rating:				
Dimension 2: Biomedical Conditions & Complications	Vital Signs:	Is member under doctor care? ☐Yes ☐No Current medical conditions:	History of seizures? ☐ Yes ☐ No	
Rating:				
Dimension 3: Emotional, Behavioral or Cognitive Conditions & Complications	MH Diagnosis:	Cognitive Limits? ☐ Yes ☐No	Psych Medications and Dosages:	Current Risk Factors (*SI, HI, Psychotic Symptoms, Etc…):*
Rating:				
Dimension 4: Readiness to Change	Awareness/commitment to change:	Internal or External Motivation:	Stage of change, if known:	Legal problems/probation officer:
Rating:				
Dimension 5: Relapse, Continued Use or Continued Problem Potential	Relapse Prevention Skills:	Current assessed relapse risk level: ☐ High ☐Moderate ☐ Low	Longest period of sobriety:	
Rating:				
Dimension 6: Recovery/Living Environment	Living Situation:	Sober Support System:	Attendance at support group:	Issues that impede recovery:
Rating:				

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Discharge Planning: Discharge Planner Name & Contact: _____

Residence address upon discharge: _____

Treatment Setting & Provider upon discharge: _____

Has a post discharge 7-day follow up aftercare appointment been scheduled? ☐ *Yes* ☐ *No*
If no, please explain: _____

If yes please provide treatment provider name, date and time of scheduled follow-up: _____

_____

Collaboration Needs: *please indicate if collaboration is needed with any of the below including contact name and phone number:*

☐ Juvenile Justice: _____

☐ Child or Adult Protective Agency: _____

☐ School System: _____

☐ Nursing or Nursing Home Facility: _____

☐ Residential Program: _____

☐ Jail/Prison/Court System: _____

☐ Other: _____

AmeriHealth Caritas Louisiana