

TCHP Behavioral Health Authorization Form (fax 832-825-8767)

Date of Admission ___/___/___ Time of Admit _____
Requested Start Date for this Authorization ___/___/___
Level of Care: [] Inpatient/Partial RTC [] IOP/SOP
Type of Review: [] Initial [] Concurrent
Type of Care: [] Rehabilitation [] Detoxification [] Psychiatric
Precipitating Event/Concurrent

Patient's Current Location:

[] ER [] Jail/Detention Facility [] Provider's Office Home/Community

Demographics:

Patient's Name _____ Date of Birth: _____
[] Male [] Female CHIP: [] Yes [] No Medicaid: [] Yes [] No Age: _____
Member ID#: _____ Tel #: _____
Guardian: _____
Address: _____
City/State/ZIP: _____

Facility

Name: _____ Attending: _____
Address/City/St: _____
UR Contact: _____ Tel _____
Fax _____

DSM IV-TR

Axis I: a.) _____ b.) _____
Axis II: a.) _____ b.) _____
Axis III: a.) _____ b.) _____
Axis IV: _____
Axis V: Current GAF: _____ Highest GAF prev. year: _____

Current Risks: Risk Level Scale: NA=not assessed/not applicable. 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; check risk level for each category and check all boxes that apply:

Risk to Self (SI): [] 0 [] 1 [] 2 [] 3 [] NA [] ideation [] means
Risk to Others (HI): [] 0 [] 1 [] 2 [] 3 [] NA [] ideation [] means
Current serious attempts: [] Yes [] No [] SI [] HI
Prior serious attempts: [] Yes [] No [] SI [] HI
Prior serious gestures: [] Yes [] No [] 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 Sleep disturbance (specify) _____
[] 0 [] 1 [] 2 [] 3 [] NA Hypo mania/mania _____

[] 0 [] 1 [] 2 [] 3 [] NA Lack of interest _____
[] 0 [] 1 [] 2 [] 3 [] NA Grandiosity _____
[] 0 [] 1 [] 2 [] 3 [] NA Sexuality _____
[] 0 [] 1 [] 2 [] 3 [] NA Concentration _____
[] 0 [] 1 [] 2 [] 3 [] NA Impulsiveness _____
[] 0 [] 1 [] 2 [] 3 [] NA Irritability _____
[] 0 [] 1 [] 2 [] 3 [] NA Anxiety _____
[] 0 [] 1 [] 2 [] 3 [] NA Psychosis _____

Hallucinations [] Visual [] Olfactory [] Auditory [] Tactile

Paranoid [] Yes [] No

Delusional (be specific) _____

Thought disorder [] Yes [] No

Thought Insertion [] Yes [] No

Thought broadcasting [] Yes [] No

Disorganized [] Yes [] No

[] 0 [] 1 [] 2 [] 3 [] NA Thinking/Cognition/Memory/Orientation

[] 0 [] 1 [] 2 [] 3 [] NA Activities of Daily Living

[] 0 [] 1 [] 2 [] 3 [] NA Weight Change Assoc. w/Behavioral Dx? [] Yes [] No

[] 0 [] 1 [] 2 [] 3 [] NA Medical/Physical Condition(s) account for symptoms?

Physical Exam: Done [] Yes [] No

Laboratory Testing Done [] Yes [] No

Height _____ ft. _____ in. Current weight _____ lbs BMI: _____

Family History of psychiatric, mental, neurological or substance abuse/dependence obtained? [] Yes [] No

Social History

[] 0 [] 1 [] 2 [] 3 [] NA Substance Abuse/Dependent HX

[] 0 [] 1 [] 2 [] 3 [] NA Social/Marital/Family Problems

[] 0 [] 1 [] 2 [] 3 [] NA Legal

[] 0 [] 1 [] 2 [] 3 [] NA Job/School Performance

MENTAL HEALTH TREATMENT HISTORY

Outpatient Mental Health/Psychiatric Treatment: [] No [] Yes

If "Outpatient" is checked, please indicate:

[] Unknown Outcome [] Improved [] No change [] Worse

Outpatient treatment compliance [] Unknown [] Poor [] Fair [] Good

Intensive Outpatient/ SOP Mental Health Treatment: [] No [] Yes:

If "IOP/Partial" is checked, please indicate: outcome:

[] Unknown Outcome [] Improved [] No Change [] Worse

IOP/SOP Mental Health Treatment compliance:

[] Unknown [] Poor [] Fair [] Good

Inpatient/Residential/Group Home Mental Health Treatment: [] No [] Yes

If "Inpatient/Residential" is checked, please indicate outcome:

[] Unknown [] Improved [] No Change [] Worse

Inpatient/Residential/Group Home Mental Health Treatment compliance:

[] Unknown [] Poor [] Fair [] Good

Number of psychiatric hospitalizations in the past 12 months: _____

Substance Abuse Treatment History: [] Yes [] No [] Unknown

Did they receive Outpatient IOP/SOP? Yes No

If they received "Outpatient IOP/SOP" please indicate outcome:

Unknown Improved No Change Worse

Outpatient IOP/SOP Treatment compliance?

Unknown Poor Fair Good

Did they receive Partial Hospitalization Treatment? Yes No

If the rev "IOP/Partial" is checked, please indicate outcome:

Unknown Improved No Change Worse

Partial Treatment compliance? Unknown Poor Fair Good

Did they receive Inpatient/Residential/Group Home? Yes No

If "Inpatient/Residential" is checked, please indicate outcome:

Unknown Improved No Change Worse

Inpatient/Residential Treatment compliance?

Unknown Poor Fair Good

Number of substance abuse hospitalizations in the past 12 months? _____

Other History:

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

CPS involvement in the last 12 -36 mos? Yes No

Victim of sexual or physical abuse? Yes No

Current Psychotropic Medications: None

Medication(s)	Dose	Frequency	Compliant? Y or N

Substance Use/Abuse: Compliant? No Yes Unknown

If yes, please complete below

Substance	Length current use	Amount	Frequency	Date last used

Withdrawal Symptoms: Check all that apply.

None Nausea Sweating Tremors Past DTs BR or Pulse evaluation

Vomiting Agitation Disorientation Current seizures Cramping

Hallucinations Current DTs Past Seizures Diarrhea

Indicate if using the CIWA-R, OWA or other _____ instrument to monitor?

Detoxification: Vitals BP _____ Temp: _____ Pulse: _____ RR: _____

BAL: _____ UDS: N Date: _____ Outcome: Pending Positive

If positive, for what? _____

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

Relapse Date: ____/____/____

ASAM Patient Placement Dimensions:

1. Intoxicated/WD Potential Lo Med Hi

2. Biomedical Conditions Lo Med Hi

3. Emote/Beh/Cog Conditions Lo Med Hi

4. Readiness to Change Lo Med Hi

5. Relapse Potential Lo Med Hi

6. Recovery Environment Lo Med Hi

HIV/STD/Hepatitis/TB/ Pregnancy Assessment Performed (check all done)

HIV TB Hepatitis STD Pregnancy

Treatment Request: Admit Date: ____/____/____ Requested visits ____ days

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 Other _____

Barriers to Discharge: Discharge treatment setting not available

Transportation Legal Mandate Adequate Housing/Residence

Lack of Community Support Treatment Non-Compliance Other _____

Discharge Plan:

Expected D/C Date if known: ____/____/____

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

Partial IOP/SOP Group Home Halfway House Other _____

Planned Living Arrangements: Post D/C Residence

Home (Alone or w/others) RTC/Group Home/Halfway House Shelter

Correctional Facility Foster Care Respite State Hosp. Residential

Juvenile Detention Transfer to Medical Transfer to Alternate Psych. Facility

Other _____

Discharge Planning

Contact Person Tel. #: _____

Contact Person Name: _____

Social Security Disability Referral Yes No

I acknowledge the facility is aware of the requirements for 7 and 30 day follow-up post discharge.

Signed _____

Comments _____

ADDITIONAL AREA FOR CLINICAL INFORMATION :

