INPATIENT TREATMENT REPORT (ITR) - Page One of Two

Requested Start Date for this Authorization ____/____/____

Level of Care: ❑ Inpatient ❑ 23 hr ❑ CSU ❑ Partial ❑ PRTF/RTC ❑ IOP/SOP
❑ Residential (I-IV excl. Foster Care) ❑ Foster Care ❑ Community Support Indv.
❑ MH/SA TCM ❑ 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)
0 1 2 3 na Substance Abuse/Dependent
0 1 2 3 na Job/School Performance
0 1 2 3 na Social/Marital/Family Problems
0 1 2 3 na Legal

Current weight - _____ lbs ❑ na
Height - _____ft. _____ in. ❑ na

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?*
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ 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
2. Biomedical Conditions ❑ Lo❑ Med ❑ Hi
3. Emot/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

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 dischg. 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 Placemt.
❑ 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 Placemt.
❑ 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