

New Directions Inpatient/PHP/IOP Treatment Request Form for Blue Cross and Blue Shield of Kansas Members



Demographics:

Member Name: _____ Phone# _____

Insurance ID#: _____ DOB: _____

Member Address: _____

Facility Name: _____

Facility Address: _____

Attending Prov Name: _____ Phone# _____

Attending Prof Address: _____

UR Name: _____ Phone# _____

Level of Care: Inpatient Partial IOP _____

Type of Review: Initial Concurrent Discharge

Type of Care: Mental Health Substance Abuse Detox

Requested Start Date for this Authorization: ____/____/____

Admit Date: ____/____/____ Estimated Length of Stay: _____

Precipitating Event:

DSM-IV Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____ GAF: _____ / _____
current past year

Risk/ Functional Assessment:

Current Suicidal Ideation: No Yes with ideation plan intent means

Current Homicidal Ideation: No Yes with ideation plan intent means

Current Attempt/ Gesture: _____

History of Previous Attempts: No Yes _____

History of MH TX/ Admits: _____

Work/ School/ Family Functioning: _____

Medical:

Admit/ Detox Medications: _____

Medication Changes _____

Unit/ Treatment Information:

Date of Family Meeting: None Scheduled for ____/____/____

Outcome of Family Meeting: _____

Sleep: WNL or _____

Appetite: Good Fair Poor

Interaction with peers: WNL or _____

Status On Unit: 1:1 15 min checks: SI Precautions: Unit Restriction:

Attending Groups: Yes No: Participating in Groups: Yes No:

Mental Status:

Behaviors: WNL or _____

Grooming/ hygiene/ ADL's : Good Fair Poor

Speech: WNL or _____

Mood: WNL or _____

Perception/Thought Content: WNL or _____

Orientation: Oriented x3 Not oriented Person Place Time

Current Eating Disorder: None Binging Purging Restricting
Bathroom Restriction Exercise Restriction Kcals meal planning: _____

Lab Results: _____

Weight: _____ lbs Height: _____ft _____in % IBW: _____

Other ED info: _____

Current Substance Abuse: None Unknown Yes (if yes, please complete below)
Substance *Years used* *Last used* *Amount* *Freq*

Vitals: _____

Current Withdrawal Sxs: _____

UDS: Negative: Pending: Positive: _____

Current Legal Issues: _____

Continued Stay Rationale: *(Please fill out for continued stay requests)*

Barriers to discharge: _____

Reasons for Continued Stay: _____

Other Pertinent Clinical Information:

Discharge Planning:
Expected Discharge Date: _____/_____/_____

Planned Discharge LOC: Subacute Psych Residential CD PHP IOP
Outpatient psychiatrist Therapist DBT
Case Mng 12 step program

Other: _____

Discharge Information: *(complete this area on discharge and fax to New Directions)*

Actual Discharge Date: _____/_____/_____ Discharged AMA? No Yes

Discharge LOC: Subacute Psych Residential CD PHP IOP
Outpatient psychiatrist Therapist DBT
Case Mng 12 step program

Other: _____

Primary Discharge Diagnosis: _____ Discharge GAF: _____

Aftercare Information: Not arranged Unknown Arranged

Discharge Medications: _____

Provider Name: _____ Phone#: _____

Scheduled Appt Date: _____/_____/_____ MH care CD care Med Mng

Provider Name: _____ Phone#: _____

Scheduled Appt Date: _____/_____/_____ MH care CD care Med Mng

Member/ Family Name for Follow up: _____

Relationship: _____ Home Phone #: _____

Work Phone #: _____ Cell#: _____

SIGNATURE _____

Signature of Person Completing this form *Date*

Please FAX or Mail this completed 2 page form to:

**New Directions Behavioral Health
PO Box 1627
Topeka, KS 66601-1627 (800) 952-5906
Fax #: 913-982-8176**