

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

Demographics:

MemberName: _____ 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 _____
Family Hx of Suicide Attempts: _____
Family Hx of MI or Sub Abuse: _____
History of Abuse: None Emotional Neglect Physical Sexual
Work/ School/ Family Functioning: _____
Holds a job Functions independently Compliant w/ tx Asymptomatic

Medical:

Admit Medications: _____

Medication Changes _____

Lab Results: _____
Vitals: _____

Unit Observations:

Status On Unit: 1:1 15 min checks: SI Precautions: Unit Restriction:
Attending Groups: Yes No: Participating in Groups: Yes No:
Sleep: Hypersomnia: 6-8 hrs: less than 6 hrs: Insomnia Disrupted
Appetite: Good Fair Poor
Interaction with peers: Socially approp Isolative Intrusive Other: _____

Mental Status:

Behaviors: Hyperactive Impulsive Agitated Combative
Compulsive Psychomotor Retardation Aggressive/Violent
Grooming/ hygiene/ ADL's : Good Fair Poor
Speech: Rapid Slowed Pressured Slurred Other: _____
Mood: Depressed Anxious Flat Blunted Constricted Tearful
Labile Irritable Euthymic Incongruent Other: _____
Perception/Thought Content: WNL Hallucinations Delusions Paranoia
Disorganized thoughts Obsessions Other: _____
Orientation: Oriented x3 Not oriented Person Place Time
Current Substance Abuse: None Unknown Yes (if yes, please complete below)
Substance Years used Last used Amount Freq

Current Withdrawal Sxs: _____

UDS: Negative: Positive:

Current Eating Disorder: None Binging Purging Restricting

Bathroom Restriction Exercise Restriction Kcals meal planning: _____

Weight: _____ lbs Height: _____ ft _____ in % IBW: _____

Treatment Information:

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

Outcome of Family Meeting: _____

Outpatient Providers and Date Contacted:

Primary Care Physician: _____ / _____ / _____

Psychiatrist: _____ / _____ / _____

Therapist: _____ / _____ / _____

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

Barriers to discharge: _____

Reasons for Continued Stay: _____

Discharge Planning:

Expected Discharge Date: _____ / _____ / _____

Planned Discharge LOC: Subacute Psych Residential CD PHP IOP

Outpatient psychiatrist therapist DBT Case Mng

12 step program Other: _____

Other Pertinent Clinical Information: _____

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

Provider Name: _____ Phone#: _____

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

Provider Name: _____ Phone#: _____

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

Aftercare Plan sent to providers within 1 business day of discharge: Yes No

Member/ Family Name for Follow up: _____

Relationship: _____ Home Phone #: _____

Work Phone #: _____ Cell#: _____

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