INPATIENT TREATMENT REPORT (ITR)

Requested Start Date for this Authorization (mo/day/year):

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 (mo/day/year):
Patient Policyholder ID #: Telephone Number#:
Patient's City/State:
Subscriber's Employer/Benefit Plan:
Facility Name: Facility ID:
Facility Address (Street/City/State):
Attending Provider:
Attending Provider's Phone #:
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 previous year:

Current Risks:
Risk Level Scale: 0=none, 1=mild, 2=moderate, ideation with either plan or history of attempts; 3=severe, ideation AND plan, with either intent or means; n/a=not assessed). Choose risk level for each category, and check all boxes that apply:

Risk to Self (SI): ☐0 ☐1 ☐2 ☐3 ☐n/a with ☐ideation ☐intent ☐plan ☐means
Risk to Others (HI): ☐0 ☐1 ☐2 ☐3 ☐n/a with ☐ideation ☐intent ☐plan ☐means

Current serious attempts: ☐Yes ☐No Choose: ☐SI ☐HI
Prior serious attempts: ☐Yes ☐No Choose: ☐SI ☐HI
Prior serious gestures: ☐Yes ☐No Choose: ☐SI ☐HI
Date of the most recent attempt or gesture (mo/day/yr):

Current Impairments:
Scale: 0=none, 1=mild, 2=moderate, 3=severe, n/a = not assessed
☐0 ☐1 ☐2 ☐3 ☐n/a Mood disturbance (depression or mania)
☐0 ☐1 ☐2 ☐3 ☐n/a Anxiety
☐0 ☐1 ☐2 ☐3 ☐n/a Psychosis
☐0 ☐1 ☐2 ☐3 ☐n/a Thinking/cognition/memory
☐0 ☐1 ☐2 ☐3 ☐n/a Impulsive/reckless/aggressive
☐0 ☐1 ☐2 ☐3 ☐n/a Activities of Daily Living
☐0 ☐1 ☐2 ☐3 ☐n/a Weight loss assoc. w/behave Dx: ☐ gain ☐ loss ☐ n/a of
Pounds in last 3 months: Current Weight: lbs
Current Height ft inches
☐0 ☐1 ☐2 ☐3 ☐n/a Medical/physical condition(s)
☐0 ☐1 ☐2 ☐3 ☐n/a Substance abuse/dependent
☐0 ☐1 ☐2 ☐3 ☐n/a Job/school performance
☐0 ☐1 ☐2 ☐3 ☐n/a Social/marital/family problems
☐0 ☐1 ☐2 ☐3 ☐n/a Legal

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/Group Home" 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:

PATIENT'S NAME:

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. *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: *(Please check all that apply)*
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 months? ☐ Yes ☐ No
Active gang involvement in the last 12 months? ☐ Yes ☐ No
DSS/CPS involvement in the last 12 months? ☐ Yes ☐ No
Victim of sexual or physical abuse? ☐ Yes ☐ No

Current psychotropic meds? ☐ Yes ☐ No *If yes, please complete below:*

Current Psychotropic Medications:

Meds.	**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 seizure
☐ Cramping	☐ Hallucinations	☐ Current DTs	☐ Past seizures

Vitals: *(If Detox or Relevant):* BP: Temp: Pulse: Resp:
BAL:
UDS: ☐ Yes ☐ No Outcome: ☐ Pending ☐ Negative ☐ Positive
If positive, for what? CIWA:
Longest period of sobriety: ☐ <6 mos. ☐ 6 mos – 2 yrs ☐ 2+ yrs ☐ None ☐ Unknown
Relapse Date: (mo/day/year):

ASAM Dimensions:

1. Intoxicated/WD potential:	☐ Lo ☐ Med ☐ Hi	4. Readiness to change:	☐ Lo ☐ Med ☐ Hi
2. Biomedical conditions:	☐ Lo ☐ Med ☐ Hi	5. Relapse potential:	☐ Lo ☐ Med ☐ Hi
3. Emot/Beh/Cog conditions:	☐ Lo ☐ Med ☐ Hi	6. Recovery environment:	☐ Lo ☐ Med ☐ Hi

Treatment Request: **Admit Date:** (mo/day/year):
(Note well: Each level of care, ECT and/or Psych Testing requires separate precertification.)
Is family/couples therapy indicated? ☐ Yes ☐ No If yes, date of appt (mo/day/year):
☐ 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 discharge plan ☐ other:

Barriers to Discharge: ☐ discharge treatment setting not available ☐ transportation ☐ legal mandate ☐ adequate housing/residence ☐ lack of community supports ☐ 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 (mo/day/year):
Estimated return to work date (mo/day/year):
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 ☐ with others) ☐ nursing home/SNF/assisted living ☐ RTC/group home/halfway house ☐ shelter ☐ correctional facility ☐ foster care ☐ respite ☐ state hospital ☐ residential placement ☐ juvenile detention ☐ transfer to medical ☐ transfer to alternate psych facility ☐ other:

Discharge Information: *(to be included upon discharge):*
Actual discharge date (mo/day/year):
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 ☐ 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 ☐ with others) ☐ nursing home/SNF/assisted living ☐ RTC/group home/halfway house ☐ shelter ☐ correctional facility ☐ foster care ☐ respite ☐ state hospital ☐ residential placement ☐ juvenile detention ☐ transfer to medical ☐ transfer to alternate psych facility ☐ other:

Patient/Family member name for follow up:

Relationship:
Phone #: ☐ Do not know
Aftercare behavioral health provider: ☐ not arranged ☐ do not know
Aftercare provider name:
Aftercare provider telephone #:
Scheduled appointment date (mo/day/year):
Type of appointment: ☐ mental health ☐ substance abuse ☐ medication management

Prescribing physician: ☐ not arranged ☐ do not know
Prescribing physician name:
Prescribing physician telephone #:
Prescriber: ☐ PCP ☐ psychiatrist ☐ other prescriber type
Scheduled appointment date (mo/day/year):

Signature of person completing this form: Date (mo/day/year)