

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

Admit Date for this Service: ___/___/___

Service Requested: Psych Rehab-site Mobile Psych Rehab
 Club House

Rehabilitation Program: _____

Type of Review: Initial Concurrent

Type of Service: mental Health

Reason for referral: _____

Member's Current Location:

Rehabilitation Center Other

DEMOGRAPHICS:

Member's Name: _____ Date of Birth: _____

Member MA ID#: _____

Facility: _____ Facility ID: _____

Facility Address/City/State: _____

Contact Name: _____

Contact Phone: _____ Contact Fax: _____

DSM-IV DIAGNOSIS:

Axis I: 1.) _____ 2.) _____

Axis II: 1.) _____ 2.) _____

Axis III: 1.) _____ 2.) _____

Axis IV: 1.) _____

Axis V: Current GAF: _____ Highest GAF Previous 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: S I H I

Prior Serious Attempts: Yes No Circle: S I H I

Prior Serious Gestures: Yes No Circle: S I H I

Date of the Most Recent Attempt or Gesture: ___/___/___

CURRENT CHALLENGES:

Scale: 0 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 Loss Assoc. with Eating D/O

0 1 2 3 NA Medical/Physical Conditions(s)

0 1 2 3 NA Substance Abuse/Dependence

0 1 2 3 NA Job/School Performance

0 1 2 3 NA Social/Marital/Family Problems

0 1 2 3 NA Legal

MENTAL HEALTH/PSYCHIATRIC SERVICE HISTORY:

(Please check all that apply)

Outpatient If "Outpatient", please indicate:

Outcome: Unknown Improved No Change Worse

Service Effectiveness (Non-Med): Unknown Poor Fair Good

IOP/Partial If "IOP/Partial", please indicate:

Outcome: Unknown Improved No Change Worse

Service Effectiveness (Non-Med): Unknown Poor Fair Good

Inpatient/Residential/Group Home If "Inpatient/Residential, please indicate:

Outcome: Unknown Improved No Change Worse

Service Effectiveness (Non-Med): Unknown Poor Fair Good

Number of psychiatric hospitalizations in the past 12 months: _____

Number of psychiatric hospitalizations in lifetime: _____

SUBSTANCE ABUSE SERVICE HISTORY: None Unknown

(Please check all that apply)

Outpatient If "Outpatient", please indicate:

Outcome: Unknown Improved No Change Worse

Service Effectiveness (Non-Med): Unknown Poor Fair Good

IOP/Partial If "IOP/Partial", please indicate:

Outcome: Unknown Improved No Change Worse

Service Effectiveness (Non-Med): Unknown Poor Fair Good

Inpatient/Residential If "Inpatient/Residential", please indicate:

Outcome: Unknown Improved No Change Worse

Service Effectiveness (Non-Med): Unknown Poor Fair Good

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

Number of substance abuse hospitalizations in lifetime: _____

CO-OCCURRING DIAGNOSIS Yes No

If yes, What Services are in place? _____

PSYCHOTROPIC MEDICATIONS:

Current psychotropic meds? Yes No (If yes, please complete below.)

Medication	Dose	Frequency	Usually Adherent?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Is member engaged in his/her Recovery? Yes No

If no, why not? _____

SUPPORT SYSTEMS:

Who is it? _____

Are they involved in the service? Yes No

What supports are being Explored:

REHABILITATION PLAN GOALS

- 1.) _____
- 2.) _____
- 3.) _____

Report Rehabilitation Plan Progress for continued stay.

- 1.) _____
- 2.) _____
- 3.) _____

Reason for Continued Stay: Wants To Set Another Goal

Has Not Achieved Service Goals Finalize After- Service Plan

Other _____

Barriers to Service Completion: Service Setting Not Available

Transportation Adequate Housing/Residence

Lack of Community Support Not participating in Service.

Other _____

MEMBER'S STRENGTHS: Holds job Symptoms Relieved

Manages Medications Performs ADL's Abstinent Other

AFTER-SERVICE PLAN:

Planned Service after Psych Rehab: Outpatient Partial IOP/SOP

Group Home Halfway House Residential

Other _____

Planned After-Service Residence: Home (Alone With Others)

Nursing Home/Assisted Living Group Home/Halfway House Shelter

Correction Facility Respite State Hospital Residential Placement

Transfer to Medical Other _____

Start date for Authorization: _____

Units: _____

Days Per Week _____

Hours Per Day _____

VBH-PA PSYCH REHAB (ARF) Auth Request Form) Pg. 2 of 2

By completing this box, you will assure that this page is linked to the first page should they become separated. Thank you.

Member's Name: _____

Member's ID Number: _____

Member's Date of Birth: ___/___/___