

## Higher Level of Care Registration/Concurrent Review Template

All fields with \* are required.

\*Requested Start Date for this Request: \_\_\_\_\_ \*Admit Date: \_\_\_\_\_

\*Has the member already been admitted to the facility?  Yes  No

\*Type of Service:  Mental Health  Substance Use

\*Level of Care:  Inpatient  Partial Hospitalization  
 Inpatient Detoxification  Freestanding Detoxification  Residential Rehabilitation

\*Type of Review:  Initial Precertification  Concurrent Review

### Demographics:

\*Member Name: \_\_\_\_\_ \*Member Medicaid ID: \_\_\_\_\_

\*Member DOB: \_\_\_\_\_ \*Member Follow-Up Contact Information (phone #, email, or N/A) \_\_\_\_\_

\*Preparer Name: \_\_\_\_\_ \*Preparer Phone #: \_\_\_\_\_

\*Name of Facility/Institution Referring Member to You: \_\_\_\_\_

\*If Child, DCF Legal Status:  Committed  CPS in Home  Delinquency Pending  Dual Committed  
 FWSN  FWSN Pending  Juvenile Justice  N/A  Non Committed  Open Investigation  
 Order of Temporary Custody  Pending 136  Probate  Protective Supervision  
 Termination of Parental Rights  Unknown  Voluntary (Age of Majority)  Voluntary Services  
 Voluntary Services Pending

### Diagnosis:

#### Behavioral Diagnosis (Primary is required)

\*Diagnosis Code: \_\_\_\_\_ \*Description: \_\_\_\_\_

\*Diagnostic Category: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_ Description: \_\_\_\_\_

Diagnostic Category: \_\_\_\_\_

#### Medical Diagnosis (Primary is required or indicate "None" or "Unknown")

\*Diagnosis Code: \_\_\_\_\_ \*Description: \_\_\_\_\_

\*Diagnostic Category: \_\_\_\_\_

#### \*Social Elements Impacting Diagnoses (Required - Check all that apply)

- None  Educational problems  Financial problems  Housing problems (Not Homelessness)
- Occupational problems  Other psychosocial and environmental problems \_\_\_\_\_
- Problems with access to health care services  Homelessness
- Problems related to interaction with legal system / crime  Problems with primary support group
- Problems related to social environment  Medical disabilities that impact diagnosis  Unknown

#### Functional Assessment (Optional)

CDC- HRQOL  CGAS  FAST  GAF  OMFAQ  SF12  SF36  WHO DAS  
 OTHER \_\_\_\_\_ ASSESSMENT SCORE \_\_\_\_\_

**Medical Implications:**

**\*Are there any comorbid medical conditions that impact the treatment of the diagnosed MHSU conditions?**

Yes No Unknown

**\*Is the individual receiving appropriate medical care for the comorbid medical conditions?**

Yes No Unknown

**Metabolic Assessment Tool: (optional)**

Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Waist Circumference: \_\_\_\_\_

If BMI is not assessed, please indicate reason for not obtaining: \_\_\_\_\_

**Symptomatology:**

**\*Explain the reason for current admission describing symptoms and precipitant (stressor leading to decompensation). For concurrent reviews, please describe the need for continued stay, including any progress that has been made and remaining symptoms.**

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**Current Risks:**

Key: 0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

**\*Members Risk to Self:** 0 1 2 3 N/A

**\*Members Risk to Others:** 0 1 2 3 N/A

**\*Substance Use:** 0 1 2 3 N/A

**\*Legal:** 0 1 2 3 N/A

Urine Drug Screen (UDS) Completed: Yes No Unknown Date UDS Completed: \_\_\_\_\_

Outcome of UDS: Positive Negative Pending COWS: \_\_\_\_\_ CIWA: \_\_\_\_\_

UDS Positive for (Check all that apply): Cannabis Opiates Cocaine Amphetamines

Tricyclic Antidepressants Phenylpropanolamine Benzodiazepines Barbiturates

Methamphetamine PCP LSD Methadone

**\*Blood Alcohol:** \_\_\_\_\_ N/A

**Primary Issues/Symptoms Addressed in Treatment:**

**\*Indicate primary complex(es) pertinent to this request. You must complete a system complex for the primary behavioral/substance use diagnosis and the primary medical diagnosis (if one was indicated in the Diagnosis section above). Also, if you selected a 2 or 3 for any of the current risks above, you must complete the symptom complex for it below.**

- Danger to Self     
  Danger to Others     
  Psychosis     
  Child/Adolescent Behavior  
 Eating Disorder     
  Neurocognitive     
  Substance Use     
  Mood Disorder

**\*Complex Name** (from list above): \_\_\_\_\_

**\*Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:**

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**Complex Name** (from list above): \_\_\_\_\_

**Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:**

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**Complex Name** (from list above): \_\_\_\_\_

**Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:**

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**Complex Name** (from list above): \_\_\_\_\_

**Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:**

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**ASAM Dimensions (Required if request is Substance Use related):**

1. Intoxicated/WD Potential  Low  Medium  High     
 2. Biomedical Conditions  Low  Medium  High  
 3. Emotional/Behavioral Conditions  Low  Medium  High     
 4. Readiness to Change  Low  Medium  High  
 5. Relapse Potential  Low  Medium  High     
 6. Recovery Environment  Low  Medium  High

**Recovery and Resiliency:**

**\*Describe the recovery and resiliency environment to support this individual's long term recovery plan including their personal strengths and support systems available to the member. Include any needs or supports that must be put in place to assist the member's recovery.**

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**Current Psychotropic Medications:**

Medication 1 Name: \_\_\_\_\_

Start Date: \_\_\_\_\_ Date Discontinued: \_\_\_\_\_ Date Added: \_\_\_\_\_

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: \_\_\_\_\_

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Medication 2 Name: \_\_\_\_\_

Start Date: \_\_\_\_\_ Date Discontinued: \_\_\_\_\_ Date Added: \_\_\_\_\_

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: \_\_\_\_\_

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Medication 3 Name: \_\_\_\_\_

Start Date: \_\_\_\_\_ Date Discontinued: \_\_\_\_\_ Date Added: \_\_\_\_\_

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: \_\_\_\_\_

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With respect to all medications above, please enter any additional details that would assist in coordinating care:

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Medication changes this month: Yes No

Medication requires serum blood levels: Yes No

Date of Most Recent blood draw: \_\_\_\_\_

Unknown

**Best Practices Endorsement:**

**\*I endorse that I follow best practice guidelines for the primary behavioral diagnosis:** Yes No

If you answered no to the question above, please explain why you will not follow best practice guidelines:

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**\*Care Planning Team Includes:** AO/Parole Staff DCF DDS Case Manager Family/Guardian  
Member Milieu Staff Medical ASO Outpatient Provider Peer/FPS Psychiatrist/Nurse  
School LMHA (if managed by)

**\*Is there a child or adult in member's household in need of any support or service:** Yes No

If Yes, select primary support/services needed: Behavioral Health Medical Social Services  
Transportation Housing

If Yes, describe the support/service that is recommended: \_\_\_\_\_

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**\*Is service requested for HLOC because appropriate LLOC is not available:** Yes No

If Yes, what LLOC was needed and not available for the member: Crisis Stabilization Obs. Bed  
IICAPS MST MDFT FFT FST Therapeutic Mentoring  
PHP IOP EDT Home Visit Home Health Psych Testing  
Meth. Maintenance EPSDT Outpatient RTC Group Home

If Yes, what is the reason why appropriate LLOC is not available: Does not exist in geographic area  
At capacity/no openings Does not provide specialty needed Member Declined  
Hours not Available Determine Not Crisis Family Decline  
Other \_\_\_\_\_

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**Discharge Information:**

**\*Planned discharge Level of Care:** Community Support Team Outpatient Outpatient  
Targeted Case Management Inpatient 23 Hour CSU Partial Hospitalization  
Residential Treatment Center Group Home Halfway House Day Services IOP/SOP  
Alternative Community Support Day Treatment Foster Care In-Home Family Services  
Placement Services PRTF

**\*Planned Discharge Residence:** AWOL Correctional Facility Foster Home  
Group Home (non therapeutic) Group Home Pass Group Home (therapeutic)  
Home Independent Living Juvenile Detention Nursing Home/SNF/Assisted Living  
PRTF Community PRTF Solnit RTC State Hospital  
Supervised/Supportive Housing Therapeutic Foster Care Transfer to Alt. Psych or Rehab Facility  
Transfer to Medical Unknown

**\*Expected Discharge Date:** (only required on concurrent reviews) \_\_\_\_\_