

CT BHP REGISTRATION TEMPLATE

ALL FIELDS WITH * ARE REQUIRED

Provider EDS/CMAP ID # (Medicaid 9-digit ID): _____

Facility/Provider Name: _____ Contact # & Ext: _____

Facility/Provider Service Location: _____

Name of user who filled out this form: _____ Credentials/Title: _____

Member Name: _____

Medicaid/Consumer ID#: _____ DOB: _____ and/or SSN: _____

LEVEL OF CARE: Intensive Outpatient EDT Outpatient Methadone Maintenance Ambulatory Detoxification
 Case Management IICAPS MDFT MST FFT

QUESTIONS:

- 1) * Requested start date (EX: 09/01/2010): _____
- 2) * Is this a new registration for a client already in outpatient treatment within your agency/practice? YES NO
- 3) * Is member stepping down to outpatient from a higher level of care within your agency/practice? YES NO N/A
- 4) * Referral Source: (who encouraged this member to obtain services?)
 Community Collaborative Court-Ordered/Legal CT BHP ASO DCF DDS DMHAS EMPS
 Hospital Emergency Dept. Other Other BH Provider PCP / Medical Provider School
 Self / Family Member Step Down Inpatient /Intermediate LOC
- 5) *First phone or walk-in contact with member or parent/guardian: Date: _____
- 6) *First contact was: Telephone Walk-in
- 7) *Referral type: Emergent Routine Urgent
 - a. If Routine or Urgent:
 Date of 1st Appt. Offered to Member: _____ Date of 1st Appt. Accepted by Member: _____
 Date of 1st Face-to-Face Clinical Evaluation: _____
 If Applicable, Number of no-shows/cancellations prior to first appt.? (Indicate #) _____
 - b. If Emergent:
 Date and Time Presented at the Clinic: ____/____/____ DATE _____ AM / PM
 Date and Time of Clinical Evaluation: ____/____/____ DATE _____ AM / PM

8) Behavioral Diagnoses (Primary is required)
 *Diagnosis Code: _____ *Description _____
 *Diagnostic Category: _____
 Diagnosis Code: _____ Description _____
 Diagnostic Category: _____

9) Primary Medical Diagnoses (Primary is required or indicate "None" or "Unknown")
 *Diagnosis Code: _____ *Description _____
 *Diagnostic Category: _____
 Diagnosis Code: _____ Description _____
 Diagnostic Category: _____

10) *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 Unknown
- Medical disabilities that impact diagnosis or must be accommodated for in treatment

11) Functional Assessment (Optional)

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

12) Current Risks

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

- A. *Members Risk to Self** 0 1 2 3 N/A
- B. *Members Risk to Others:** 0 1 2 3 N/A

13) Current Impairments

A. *Mood Disturbances (Depression or Mania)

- 0 1 2 3 N/A

C. *Anxiety

- 0 1 2 3 N/A

D. *Psychosis / Hallucinations / Delusions

- 0 1 2 3 N/A

F. *Thinking/Cognitive/Memory/Concentration Problems

- 0 1 2 3 N/A

H. *Impulsive/Reckless/Aggressive Behavior

- 0 1 2 3 N/A

J. *Activities of Daily Living Problems

- 0 1 2 3 N/A

L. *Impairments Related to Loss/Trauma

- 0 1 2 3 N/A

B. *Weight Changes Associated with Behavioral Diagnosis

- 0 1 2 3 N/A

For 2 or 3 rating:

- Weight Gain Loss N/A
- Past 3 mos _____ Lbs N/A
- Current Wt _____ Lbs N/A
- Height _____ Ft _____ In N/A

E. *Medical / Physical Conditions

- 0 1 2 3 N/A

G. *Substance Abuse / Dependence

- 0 1 2 3 N/A

For 2 or 3 rating: Check all that apply

- Alcohol Illegal Drugs Prescription Drugs

I. *Job/School/Performance Problems

- 0 1 2 3 N/A

K. *Social Functioning/Relationships/Marital/Family Problems

- 0 1 2 3 N/A

M. *Legal

- 0 1 2 3 N/A

For 1, 2 or 3 rating: Check all that apply

- Juv Jus Probation Parole Other Court

- 14) Does member have co-occurring mental health and substance abuse conditions?** Yes No Not Assessed

Treatment Plan

- 15. *Is psychiatric medication evaluation or medication management visit indicated?** Yes No

- 16. *Have you provided information regarding Peer Support or Self Help Options?** Yes No

- 17. *Do family members or significant others actively participate in the member's treatment or recovery?** Yes No

If yes, are any of the family members/significant others receiving their own MH or SA treatment? Yes No

18. Have you obtained consent to contact:

- a. *School:** Yes No Denied Adult not attending school
- b. *Medical provider:** Yes No Denied
- c. *Previous behavioral health treatment provider:** Yes No Denied N/A

19. *The treatment plan was developed with the member (or his/her guardian) and has measurable time limited goals.
 Yes No
20. *Does a documented goal oriented treatment plan exist? Yes No
21. *Anticipated / Target Date for achievement of current treatment plan goal: _____

SPECIAL POPULATIONS

FEDERAL REPORTING REQUIREMENTS ONLY FOR MEMBERS 0-18 YEARS OF AGE

22. SED (Seriously/Severely Emotionally Disturbed): YES NO UNKNOWN
23. Co-Occurring Disorder: YES NO UNKNOWN
24. Living Situation:
 Crisis Stabilization Residential Foster Care (Standard) Foster Care (Therapeutic or Professional)
 Group Home Homeless Independent living with Supports Jail / Correctional Facility Private Residence
 Psychiatric Residential Treatment Facility Residential Treatment Center Safe Home Shelter
25. Within the past 12 months has the child/youth been arrested? YES NO UNKNOWN
26. Within the past 12 months has the child/youth been suspended / expelled? YES NO UNKNOWN

ADDITIONAL REQUIRED QUESTIONS ONLY FOR METHADONE MAINTENANCE/AMBULATORY DETOX:

Methadone Maintenance

- * Is the member currently maintained on Methadone? YES NO
- a. If **yes**, how long has the member received Methadone services?
 6 mos or less 7 mos – 1 yr 1-3 yrs 3-5 yrs 5 yrs >
- b. If **no**, what has been the duration of the member's opioid use?
 Less than 1 yr 1-3 yrs 3-5 yrs 5 yrs or >
- *What other services are included in the treatment plan?
 Community Support (AA/NA) IOP/PHP Other Behavioral Health Services Outpatient Therapy
 PCP / MD Follow-up
- *What is the ultimate treatment goal? Abstinence Methadone Maintenance

Ambulatory Detox

- *From what substance is the member in need of detoxification? (select all that apply)
 Alcohol Benzodiazepines Opiates
- *Has the member had a previous detox in any setting in the past year?
 YES NO
- If **yes**, number of detoxes in the past year?
 1 2 3 4+
- *What is the identified discharge plan? (Select all that apply)
 Community Support (AA/NA) IOP/PHP Methadone Services Other Behavioral Health Services
 Outpatient Therapy PCP/MD Follow-up