



Residential Detoxification Service Request Form

Phone Number: 1-800-818-5837 Fax Number: 1-866-617-4967

Section 1 Member Information			
Member Name: (Last, First, MI)	Date of Birth: / /	Member I.D.:	
Address: (No., Street, City, State, Zip)		Phone Number: ()	
Sex:	Date submitted:		
Age:	Date of admission:		
Section 2 Facility Information			
Facility Name: Contact Person:	Address:	Phone Number: ()	Fax Number: ()
TPI: NPI:	Is Member court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Referral Source: <input type="checkbox"/> Admitting MD <input type="checkbox"/> MH Professional <input type="checkbox"/> Other (list):			
Section 3 Factors for Admission (For admission complete all sections except section 6)			
Impaired neurological functions/altered mental state as evidenced by:	Failure of two previous treatment episodes of outpatient detoxification: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Extreme depression: <input type="checkbox"/> Yes <input type="checkbox"/> No	History of recent seizures or past history of seizures on withdrawal: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Disorientation to self: <input type="checkbox"/> Yes <input type="checkbox"/> No	Presence of any presumed new asymmetric and/or focal findings: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Alcoholic hallucinations: <input type="checkbox"/> Yes <input type="checkbox"/> No	Unstable vital signs combined with a history of past acute withdrawal syndromes: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Toxic psychosis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Clinical condition (e.g., agitation, intoxication, or confusion) which prevents satisfactory assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Altered level of consciousness: <input type="checkbox"/> Yes <input type="checkbox"/> No	Serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Section 4 Medical Complications (e.g., GI bleeding; gastritis; anemia, severe; diabetes mellitus, uncontrolled; hepatitis; malnutrition; cardiac disease, hypertension, etc.)			
Section 5 Psychiatric Symptoms			
Severe neurological and/or psychological symptoms: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Danger to self or to others: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mental confusion and/or fluctuating orientation: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Section 6 Continued Stay (complete only sections 1, 6, 7 if additional detoxification days are required)			
Unstable vital signs: <input type="checkbox"/> Yes <input type="checkbox"/> No	Continued disorientation: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Abnormal laboratory findings related to chemical dependency: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cognitive deficit related to withdrawal affecting the client's ability to recognize alcohol/drug use as a problem: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Laboratory finding that a drug has not sufficiently cleared the client's system: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Major medical complications continuing to present a health risk:			
Major psychiatric complication continuing to present a health risk or severe neurological and/or psychological symptoms have not been satisfactory reduced:			
Section 7 Number of detoxification days requested:			
Authorization #:	Date:		
Signature:	Provider license number:		