

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 5)

Client is medically stable and not in acute withdrawal: <input type="checkbox"/> Yes <input type="checkbox"/> No	Client is coherent, rational, and oriented for treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No
Client is not bed-confined or has no medical complications that would hamper participation in the residential service: <input type="checkbox"/> Yes <input type="checkbox"/> No	Client can comprehend and understand the materials presented: <input type="checkbox"/> Yes <input type="checkbox"/> No
Client manifests severe social isolation or withdrawal from social contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No	Client can participate in rehabilitation/treatment process: <input type="checkbox"/> Yes <input type="checkbox"/> No
Client lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Client will be able to improve and/or internalize his/her motivation toward recovery: <input type="checkbox"/> Yes <input type="checkbox"/> No
Clients family/significant others are opposed to the client's treatment efforts and are not willing to participate in the treatment process: <input type="checkbox"/> Yes <input type="checkbox"/> No	Interventions, treatment goals, and/or contracts are in place to help the client deal with or confront the blocks to treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No
Family members/significant other(s) living with the client manifest current chemical dependence disorders, and are likely to undermine treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No	Client's chemical substance use is excessive, and the client has attempted to reduce or control it, but has been unable to do so: <input type="checkbox"/> Yes <input type="checkbox"/> No
Logistic impairments preclude participation in an outpatient treatment service: <input type="checkbox"/> Yes <input type="checkbox"/> No	Client's daily activities revolve around obtaining, using, and/or recuperating from the effects of chemical substances and the client requires a secured environment to control the client's access to chemical substances: <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4 Adolescents Clients Only

Adolescent is assessed as manifesting physical maturation at least in middle adolescent range: <input type="checkbox"/> Yes <input type="checkbox"/> No
History of the adolescent reflects cognitive development of at least 11 years of age: <input type="checkbox"/> Yes <input type="checkbox"/> No
History of inability to function within the expected age norms despite normal cognitive and physical maturation: <input type="checkbox"/> Yes <input type="checkbox"/> No
Recent history of moderate/severe conduct disorder/impulsive disregard for social norms and rights of others: <input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty in meeting developmental expectations in a major area of functioning to an extent which interferes with the capacity to remain behaviorally stable: <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 5 Continued Stay (complete only sections 1, 5, 6, 7 if additional residential days are required)

Client recognizes/identifies with the severity of the alcohol/drug problem, but demonstrates minimal insight into defeating use of alcohol/drugs and the client is progressing in treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No
Client identifies severity of alcohol/drug problem and manifests insight into relationship with mood-altering chemicals, yet does not demonstrate behaviors indicating problem solving skills necessary to cope with the problem: <input type="checkbox"/> Yes <input type="checkbox"/> No
Client would predictably relapse if moved to a lesser level of care: <input type="checkbox"/> Yes <input type="checkbox"/> No
Documentation in the medical record indicates an intervening medical or psychiatric event which was serious enough to interrupt rehabilitation/treatment, but the client is again progressing in treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No
Documentation in the medical record indicates that the client is being held pending an immediate transfer to a psychiatric, acute medical services, or inpatient detoxification alcohol/drug service: <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 6 DSM-IV Diagnostic Codes/Service Request

Axis I:	Axis II:
Axis III:	Axis IV: Axis V GAF:

Section 7 Number of residential days requested:

Authorization #:	Date:
Signature:	Provider license number: