



Service Request Form for Extended Psychiatric Inpatient Admission
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:
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Section 2 Facility Information

Name (Contact): Address:	Phone Number: () ()	Fax Number: () ()
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TPI: NPI:	Is Member court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Referral Source: Admitting MD MH Professional Other (list):

No. of additional hospital days requested: Dates / / to / /

Section 3 Updated Clinical Presentation

a. Psychosis:	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions	<input type="checkbox"/> Loose Associations	<input type="checkbox"/> Dissociation	<input type="checkbox"/> Inappropriate Affect
b. Mood:	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Hypomania	<input type="checkbox"/> Mania	<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Concentration
	<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Loss of Motivation / Pleasure		<input type="checkbox"/> Worthlessness / Guilt	
c. Anxiety:	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Chronic Worrying	<input type="checkbox"/> Obsessive Thoughts	<input type="checkbox"/> Compulsive Behaviors	
	<input type="checkbox"/> Hyper Vigilance	<input type="checkbox"/> Phobia			
d. Cognitive:	<input type="checkbox"/> Dementia	<input type="checkbox"/> Delirium	<input type="checkbox"/> Distractible		
e. Somatic:	<input type="checkbox"/> G. I.	<input type="checkbox"/> Pain	<input type="checkbox"/> Conversion / Pseudoneurologic		
f. Development Disorders:	<input type="checkbox"/> Autism		<input type="checkbox"/> Aspergers	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Other Learning Problems
g. Disruptive Behavior:	<input type="checkbox"/> Oppositional/Conduct	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Attention
h. Substance:	<input type="checkbox"/> Abuse	<input type="checkbox"/> Dependence	(Specify Type) _____		
i. Learning/School/Work Problems: _____					
j. Other Symptoms (Specify) _____					
k. Suicidal Ideation: <input type="checkbox"/> Yes <input type="checkbox"/> No		Homicidal Ideation: <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Self Harm: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 4 Treatment Progress

<i>(Relevant clinical/diagnostic information about the patient from the past 72 hours; include any DSM-IV changes):</i>	

Section 5 Current Psychiatric Medication Regimen

Any changes in psychiatric medications:	Dosage:
1.	
2.	
3.	

Section 7 Discharge

New Projected discharge date (required): / /
Provider Information:
Aftercare Plan:

Section 8 BH Authorization

Authorization #:	Approved Duration:
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Section 9 Attending Provider Information

Signature (attending MD):	Date: / /
Print Name:	Provider License Number:

This is not a guarantee of benefits, only a review of the requested services for appropriateness and necessity. Reimbursement is based on the benefits available at the time of the service.

Signature:	Title:
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**Please attach additional information, if necessary.*