

## ADULT AND ADOLESCENT SA CLINICAL REVIEW QUESTIONS

Information requested	How to complete this section
Requested Start Date for this Authorization	This should be the admit date for a new request or the first day of the continued stay request
Level of Care	Please see Provider Relations Handbook for Level of Care definitions
Tx Unit/Program	If the patient is on a specialty unit please advise, ie. Eating Disorder Unit

**Type of Review:**

Option	Definition
Prospective	The patient has not started the program.
Concurrent	The patient is currently enrolled in the program.
Discharge	The patient is being released from the program.
Retrospective	The patient has already been admitted and released prior to submission of this form.

Information requested	How to complete this section
Type of Care	Please select the primary diagnosis if patient is being treated for dual diagnosis
Precipitating Event	What has happened to cause the patient to be admitted now?
Member's Current location	Where is the member at this time?

**Demographics:**

Information requested	How to complete this section
Fac. ID#	The ValueOptions facility ID#
Attending Provider, and Attending Provider Phone #	This is the provider who will follow the member during admission.
UR Name and UR Phone #	This is the contact at the facility for clinical information

Information requested	How to complete this section
DSM-IV Diagnosis	All five Axis are required. List primary and secondary for each. Please see DSM for further instruction.

**Current Risks:**

Information requested	How to complete this section
Risk to self (SI)	Indicate member's level of, or absence of, suicidality by circling the appropriate value, and checking all boxes that apply. <b>This must be completed</b>
Risk to others (HI)	Indicate potential for, or absence of, violence and/or abuse by circling the appropriate value, and checking all boxes that apply. <b>This must be completed</b>
Current Serious attempts	Has a serious attempt occurred during this course of treatment? If yes circle SI and/or HI as appropriate
Prior Serious attempts	Has serious attempts happened in the past? If yes circle SI and/or HI as appropriate
Prior Serious gestures	Have there been serious gestures in the past? If yes circle SI and/or HI as appropriate

**Current Impairments:** (please select/circle one value for each type of impairment)

Rating	Definition
0 = none	No evidence of impairment
1 = mild	Occasional impairment or difficulties, but no interference with normal daily activities
2 = Moderate	Currently experiencing difficulties, frequent disruption in daily activities, requires periodic or continuous assistance with some tasks
3 = Severe	Currently experiencing severe symptoms, potential risk for harm to self/others, severe distress and/r disruption in daily activities
na = not assessed	Impairment was not assessed – <b>Please note use of NA may result in additional questions to ascertain this information.</b>

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**Mental Health/Psychiatric Treatment History:** (If none or unknown please check none or unknown. If known complete the following section)

Information requested	How to complete this section
Treatment Compliance (non-med)	Compliant with aspects of their treatment that do not include medications. <ul style="list-style-type: none"> <li>• Poor -- Member complies with few (Less than 50%) of the recommendations in his/her treatment plan.</li> <li>• Fair -- Member complies with some (More than 50% but less than 75%) of the recommendations in his/her treatment plan.</li> <li>• Good -- Member complies with most (At least 75%) of the recommendations in his/her treatment plan</li> </ul>
Number of psychiatric hospitalizations in the past 12 months	The total number of “24 hour events” for Psych Hospital in the past 12 months. An estimate is okay.
Number of psychiatric hospitalizations in lifetime	The total number of “24 hour events” for Psych Hospital in his/her lifetime. An estimate is okay.
Current Psychotropic Medications:	

**Substance Use/Abuse:** If yes, please complete below

Information requested	How to complete this section
Substance, Total Yrs Use, Length current use, amount, frequency chart	An estimate is okay.
Withdrawal Symptoms	If this is a detox admission this needs to be complete
Relapse Date	What is the most recent Relapse date?

**ASAM Dimensions:**

Information requested	How to complete this section
Intoxicated/Withdrawal Symptoms	<ul style="list-style-type: none"> <li>• Low – Not under the influence; no withdrawal potential</li> <li>• Medium – Recent use, potential for intoxication; presenting with initial withdrawal symptoms</li> <li>• High – Severe withdrawal history; presenting with seizures, CIWA score greater than 10</li> </ul>
Medical Conditions	<ul style="list-style-type: none"> <li>• Low – No current medical problems; no diagnosed medical condition; no care from PCP or prescribed meds</li> <li>• Medium – Diagnosed medical condition; care from PCP; problematic response to conditions and/or care</li> <li>• High – Life threatening medical condition; medical problems interfering with treatment; hospitalization needed</li> </ul>
Psychiatric Co-Morbidity	<ul style="list-style-type: none"> <li>• Low – No current cognitive/emotional/behavioral conditions</li> <li>• Medium – Psychiatric Symptoms, including cognitive, emotional, behavioral; complications interfering with recovery efforts</li> <li>• High – Active DTO/s, S/HI; destructive, violent, or threatening behaviors, refusing to attend program schedule</li> </ul>
Motivation for Treatment	<ul style="list-style-type: none"> <li>• Low – Accepting need for treatment; attending, participating, and can ID future goals, plans</li> <li>• Medium – Ambivalent about treatment; seeking help to appease others; avoid consequences</li> <li>• High – Denial of need for treatment despite severe consequences; refusing or is unable to engage to DIM3, DIM5 symptoms interfering</li> </ul>
Relapse Prevention	<ul style="list-style-type: none"> <li>• Low – Recognizes onset signs; uses coping skills with CD or psychiatric problems</li> <li>• Medium – Limited awareness of relapse triggers or onset signs</li> <li>• High – Beliefs problematic re: continued CD use despite attendance; revisions in treatment plan; unable to recognize relapse triggers or onset signs, or recognize and employ coping skills</li> </ul>
Recover Environment	<ul style="list-style-type: none"> <li>• Low – Supportive Recovery environment, with accessible MH, CD Support</li> <li>• Medium – Moderately supportive with problematic access to MH, CD support</li> <li>• High – Environment does not support recovery behaviors or efforts; resides with active substance users or abusive</li> </ul>

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individuals

**Treatment Request:**

Information requested	How to complete this section
Admit Date	Date of this admission
Frequency of program	How often is member attending Ex: 3 x/week
Reason for continued stay	Check all that apply
Barriers to discharge	Check all that apply
Baseline Functioning	Check all that apply

**Adult/Child Additional Information:**

Information requested	How to complete this section
How did they get to the provider?	<input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> Relative or Family Support <input type="checkbox"/> Court Order <input type="checkbox"/> Other (specify):
Probation Officer / Parole Officer?	
Known agency involvement: <b>CURRENT</b>	<input type="checkbox"/> DMR, <input type="checkbox"/> JUVENILE JUSTICE, <input type="checkbox"/> LEGAL – PROBATION / PAROLE/ <input type="checkbox"/> AWAITING DHMAS TRANSITION, <input type="checkbox"/> WIC <input type="checkbox"/> HEAD START. , <b>DCF, DMHAS</b>
Known agency involvement: <b>HISTORICAL</b>	<b>DMR, JUVENILE JUSTICE, LEGAL-PROBATION/PAROLE, WAITING DMHAS TRANSITION, WIC, HEAD START, DCF, DMHAS</b>
Relevant cultural, customs & linguistic needs:	
Relevant service needs of family members (check all that apply – add text where needed)	<input type="checkbox"/> eviction or housing issue <input type="checkbox"/> parent or other adult in home active substance abuse <input type="checkbox"/> hx of interrupted treatment <input type="checkbox"/> serious medical of member in the home <input type="checkbox"/> hx of family violence <input type="checkbox"/> Other (specify): _____
Anticipate barriers to progress?	
Additional mitigating information for consideration (text):	
Addition medical related info (check all that apply)*	<input type="checkbox"/> Pregnant <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Eating Disorder

\* Please cross reference to the Registration Screen: If any of these categories are not captured there, then add in this item. Also add a box for “other”

**Discharge Plan:**

Information requested	How to complete this section
Estimated Return to work / school date	
Planned D/C level of care	This should be completed during admission and continued stay reviews

**Discharge Information: To be completed upon discharge**

Information requested	How to complete this section
Actual Discharge Date	Date patient was discharged from program
Primary Discharge Diagnosis	Primary Diagnosis upon discharge from program
Discharge GAF:	GAF score upon discharge
Discharge Condition	Has the patient condition improved, worsened or had no change from treatment?
Treatment involved the following (delete??) not particularly useful	Check all that apply. This must be completed
Total # Days/Sessions used	The total number of days/sessions used during the course of treatment
Discharge plans in place?	This must be completed
AfterCare Behavioral Health Provider	If arranged enter provider’s name, telephone #, scheduled appointment date and type of appointment
Prescribing Physician	If arranged enter the physician’s name, telephone #, check what type of physician it is and appointment date

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