INTENSIVE OUTPATIENT/PARTIAL HOSPITALIZATION REQUEST FORM

Member Name: ______________________ Date of Request: ______________________

Member ID: ______________________ Date of Birth: ______________________

Provider/Facility Name: ______________________

Program Name: ______________________ Contact Phone Number: ______________________

Address: ______________________

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Physician Overseer: ______________________

Diagnosis: ______________________ ICD-10: ______________________

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Diagnosis: ______________________ ICD-10: ______________________

Date of Last Inpatient Admission: ______________________ Expected Adherence to the Program: ________ %

Potential For Non-Adherence: ☐ Y ☐ N Present Adherence to the Program: ________ %

Available Support System: ☐ Y ☐ N Adequate Support System: ☐ Y ☐ N

Transportation Available: ☐ Y ☐ N

SYMPTOMS:	Present	Resolved	N/A
Self-destructive behavior	☐	☐	☐
Recklessness	☐	☐	☐
Impulsive behavior	☐	☐	☐
Compulsive behavior	☐	☐	☐
SI/HI w/o plan or intent	☐	☐	☐
Medication resistant	☐	☐	☐
Depression	☐	☐	☐
Anxiety	☐	☐	☐
Thought disturbances	☐	☐	☐

SYMPTOMS: (cont.)	Present	Resolved	N/A
Self-injurious behavior	☐	☐	☐
Severe cravings	☐	☐	☐
Preoccupied with substance use disorder	☐	☐	☐
Preoccupied with substance use disorder experience	☐	☐	☐
Guilt/remorse	☐	☐	☐
Drug seeking behavior	☐	☐	☐
Drug induced psychosis	☐	☐	☐
Altered mood	☐	☐	☐
Withdrawal symptoms	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

PROBLEMS:	Present	Resolved	N/A
Anger outbursts	☐	☐	☐
Withdrawn	☐	☐	☐
Nutrition	☐	☐	☐
Hygiene	☐	☐	☐
Crisis within the last 7 days	☐	☐	☐
Arrest within last 7 days	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

SERVICES PROVIDED:	Yes	No	N/A
Individual therapy	☐	☐	☐
Group therapy	☐	☐	☐
Family therapy	☐	☐	☐
Medication evaluation	☐	☐	☐

SERVICES PROVIDED:	No	N/A	Yes
Crisis planning	☐	☐	☐
Recovery based activities	☐	☐	☐
Identification of goals/triggers	☐	☐	☐
Personal recovery plan	☐	☐	☐

ADDITIONAL INFORMATION (PLEASE LIMIT TO 600 CHARACTERS):

REVIEWED 08/23/2018