Withdrawal Management Substance Use Disorder-Higher Level of Care Initial Form

Withdrawal Management Substance Use Disorder-Higher Level of Care Initial Form Details

Withdrawal Management Substance Use Disorder-Higher Level of Care Initial Form

Note: Clinical information should be entered into this form even if additional information is being attached to this request.

Please check here if this is a courtesy review.

☐

Provider/Facility Contact Information

Provider Contact/UR Name:*

Provider/UR Phone:* ___-___-____

Provider/UR Extension:

Provider/UR E-Mail:*

Provider/UR Secure Fax Number:

Is this a telephonic request? (INTERNAL OPTUM USE ONLY)**
○ Yes ◉ No

Participant Information

Participant Phone:* ___-___-____

Participant Address (upon discharge):*

Does the participant have a legal guardian?**
○ Yes ○ No

Request Details

Level of Care*

Participant in ER?**
○ Yes ○ No

Is there a valid court order?**
○ Yes ○ No

Involuntary Admission*
☐

Diagnosis and Medications

Diagnosis (include all current diagnoses):*

Are there any active medical conditions?**
○ Yes ○ No

Is participant pregnant?**
○ Yes ○ No

Current Medications (include dosage and frequency):*

Are there any barriers/issues related to the medication regimen?**
◯ Yes ◯ No

Withdrawal Management/CIWA/COWS SCORES

MOST RECENT WITHDRAWAL SCORES

Date* __/__/____ | Time(HH:MM)* | Tool* | Score* | Note

MOST RECENT WITHDRAWAL MEDICATIONS GIVEN

Date* __/__/____ | Time(HH:MM)* | WD MED* | Route* | Dose (MG)* | Note

MOST RECENT VITAL SIGNS

Date* __/__/____ | Time(HH:MM)* | BP* | Pulse* | Note

Precipitant for Admission

What was the primary precipitant/circumstances that led to this admission?*

Provide additional detail about the specific event leading to this treatment episode:*

What current symptoms, risks or impairment require treatment under the requested LOC? Please include current clinical presentation and progress.*

Substance Use Information

Was a urine drug screen (UDS) completed?**
◯ Yes ◯ No

Blood Alcohol Level:

Any history of medically-treated withdrawal seizures or DT's?**

○ Yes ○ No

Is participant currently receiving Medication Assisted Treatment (e.g. Vivitrol, Naltrexone, Methadone)?**

○ Yes ○ No

Opioid Use Disorder Diagnosis?**

○ Yes ○ No

Has MAT been tried in the past?**

○ Yes ○ No

Primary Care Physician (include name and contact information):

Outpatient Mental Health Provider (include name and contact information):

Substances

Primary Substance

Primary Substance of Use*	Route of Administration:*	Frequency of Use:*	Date of Last Use:*	Amount Last Used*	Age at First Use:*	Additional Substances?**
			__/__/____			○ Yes ○ No

ASAM Dimension Risk Ratings

Dimension 1-Acute Intoxication and/or Withdrawal

Dimension 1 Risk Rating:**

○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 1 (include CIWA or COWS, if applicable):*

Dimension 2-Biomedical Conditions and Complications

Dimension 2 Risk Rating:**

○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 2:*

Dimension 3-Emotional, Behavioral or Cognitive Conditions and Complications

Dimension 3 Risk Rating:**
○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 3:*

Dimension 4-Readiness to Change

Dimension 4 Risk Rating:**
○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 4:*

Dimension 5-Relapse, Continued Use or Continued Problem Potential

Dimension 5 Risk Rating:**
○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 5:*

Dimension 6-Recovery/Living Environment Risk

Dimension 6 Risk Rating:**
○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger

Describe Dimension 6:*

Recovery/Discharge Plan

What specific actions or treatment are planned to address the acute symptoms or behaviors?*

Facility planned discharge level of care:*

Estimated Length of Stay (ELOS)/number of days:*

Discharge Plan:*

Barriers to discharge and plans to address them to promote sustained recovery:*

Please provide any relevant information not otherwise discussed that is important for the review of this case?

Confirmation & Attestation

Please note this authorization request is not a guarantee of payment, coverage is still subject to applicable State of Maryland benefits.

I attest all of the information provided is accurate and reflected in the participant's medical record.*

Important:

1) When this form is saved a pop-up box will appear regarding an additional form being recommended.

2) Click Continue to move to the next form, DO NOT click Decline.

3) Do NOT click Cancel or the "X" on the top right of the screen before completing the Data Capture form.

4) After completing the Data Capture form, click Save and you will be returned to the authorization screen.

Data Capture Required:

Yes