Connecticut BHP
Supporting Health and Recovery

Higher Level of Care Registration/Concurrent Review Template

All fields with * are required.

***Requested Start Date for this Request:**_____ ***Admit Date:** _____

***Has the member already been admitted to the facility?** ☐Yes ☐No

***Type of Service:** ☐Mental Health ☐Substance Use

***Level of Care:** ☐Inpatient ☐Partial Hospitalization ☐Respite/SFIT
☐Inpatient Detoxification ☐Freestanding Detoxification ☐Residential Rehabilitation

***Type of Review:** ☐Initial Precertification ☐Concurrent Review

Demographics:

***Member Name:**_____ ***Member Medicaid ID:** _____

***Member DOB:**_____ ***Member Follow-Up Contact Information (phone #, email, or N/A)** _____

***Preparer Name:**_____ ***Preparer Phone #:** _____

***Name of Facility/Institution Referring Member to You:** _____

PCP Contacted Status: ☐Care plan sent to PCP ☐Discharged prior to first concurrent review
☐Facility has yet to make contact ☐Facility refused ☐Facility reminded-did not contact
☐Member AMA Discharge prior to PCP contact ☐Member has no assigned PCP
☐Member refused ☐PCP contacted ☐Not applicable

PCP Contacted Name: _____ PCP Contacted Date: _____

***If Child, DCF Legal Status:** ☐Committed ☐CPS in Home ☐Delinquency Pending ☐Dual Committed
☐FWSN ☐FWSN Pending ☐Juvenile Justice ☐N/A ☐Non Committed ☐Open Investigation
☐Order of Temporary Custody ☐Pending 136 ☐Probate ☐Protective Supervision
☐Termination of Parental Rights ☐Unknown ☐Voluntary (Age of Majority) ☐Voluntary Services
☐Voluntary Services Pending

Diagnosis:

***Behavioral Diagnosis (Primary is required)**

***Diagnosis Code:**_____ ***Description:** _____

***Diagnostic Category:** _____

Diagnosis Code:_____ Description:_____

Diagnostic Category: _____

***Medical Diagnosis (Primary is required or indicate "None" or "Unknown")**

***Diagnosis Code:**_____ ***Description:** _____

***Diagnostic Category:** _____

***Social Elements Impacting Diagnoses (Required - Check all that apply)**

☐None ☐Educational problems ☐Financial problems ☐Housing problems (Not Homelessness)
☐Occupational problems ☐Other psychosocial and environmental problems_____
☐Problems with access to health care services ☐Homelessness
☐Problems related to interaction with legal system/ crime ☐Problems with primary support group
☐Problems related to social environment ☐Medical disabilities that impact diagnosis ☐Unknown

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Functional Assessment (*Optional)*

☐CDC- HRQOL ☐CGAS ☐FAST ☐GAF ☐OMFAQ ☐SF12 ☐SF36 ☐WHO DAS

☐OTHER_____ ASSESSMENT SCORE _____

Medical Implications:

***Are there any comorbid medical conditions that impact the treatment of the diagnosed MHSU conditions?**

☐Yes ☐No ☐Unknown

***Is the individual receiving appropriate medical care for the comorbid medical conditions?**

☐Yes ☐No ☐Unknown

Metabolic Assessment Tool: *(optional)*

Current Weight:_____Height:_____Waist Circumference: _____

If BMI is not assessed, please indicate reason for not obtaining: _____

Symptomatology:

***Explain the reason for current admission describing symptoms and precipitant (stressor leading to decompensation). For concurrent reviews, please describe the need for continued stay, including any progress that has been made and remaining symptoms.**

_____
_____
_____
_____
_____
_____
_____

Current Risks:

Key: 0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

***Members Risk to Self:** ☐0 ☐1 ☐2 ☐3 ☐N/A ***Members Risk to Others:** ☐0 ☐1 ☐2 ☐3 ☐N/A

***Substance Use:** ☐0 ☐1 ☐2 ☐3 ☐N/A ***Legal:** ☐0 ☐1 ☐2 ☐3 ☐N/A

Urine Drug Screen (UDS) Completed: ☐Yes ☐No ☐Unknown Date UDS Completed: _____

Outcome of UDS: ☐Positive ☐Negative ☐Pending COWS:_____ CIWA: _____

UDS Positive for (Check all that apply): ☐Cannabis ☐Opiates ☐Cocaine ☐Amphetamines
☐Tricyclic Antidepressants ☐Phenylpropanolamine ☐Benzodiazepines ☐Barbiturates
☐Methamphetamine ☐PCP ☐LSD ☐Methadone

***Blood Alcohol:**_____ ☐N/A

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Primary Issues/Symptoms Addressed in Treatment:

***Indicate primary complex(es) pertinent to this request. You must complete a system complex for the primary behavioral/substance use diagnosis and the primary medical diagnosis (if one was indicated in the Diagnosis section above). Also, if you selected a 2 or 3 for any of the current risks above, you must complete the symptom complex for it below.**

☐Danger to Self ☐Danger to Others ☐Psychosis ☐Child/Adolescent Behavior
☐Eating Disorder ☐Neurocognitive ☐Substance Use ☐Mood Disorder

***Complex Name** (from listabove): _____

***Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:**

_____
_____
_____

Complex Name (from listabove): _____

Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:

_____
_____
_____
_____

Complex Name (from listabove): _____

Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:

_____
_____
_____
_____

Complex Name (from listabove): _____

Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:

_____
_____
_____
_____

ASAM Dimensions (Required if request is Substance Use related):

1. Intoxicated/WD Potential ☐Low ☐Medium ☐High
2. Biomedical Conditions ☐Low ☐Medium ☐High
3. Emotional/Behavioral Conditions ☐Low ☐Medium ☐High
4. Readiness to Change ☐Low ☐Medium ☐High
5. Relapse Potential ☐Low ☐Medium ☐High
6. Recovery Environment ☐Low ☐Medium ☐High

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Recovery and Resiliency:

***Describe the recovery and resiliency environment to support this individual's long-term recovery plan including their personal strengths and support systems available to the member. Include any needs or supports that must be put in place to assist the member's recovery.**

_____
_____
_____
_____
_____

Current Psychotropic Medications:

Medication 1 Name: _____

Start Date:_____Date Discontinued:_____Date Added: _____

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: _____

_____

Medication 2 Name: _____

Start Date:_____Date Discontinued:_____Date Added: _____

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: _____

_____

Medication 3 Name: _____

Start Date:_____Date Discontinued:_____Date Added: _____

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: _____

_____

With respect to all medications above, please enter any additional details that would assist in coordinating care:

_____
_____
_____

Medication changes this month: ☐Yes ☐No Medication requires serum blood levels: ☐Yes ☐No

Date of Most Recent blood draw:_____ ☐Unknown

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Best Practices Endorsement:

***I endorse that I follow best practice guidelines for the primary behavioral diagnosis:** ☐Yes ☐No

If you answered no to the question above, please explain why you will not follow best practice guidelines:

_____

_____

***Care Planning Team Includes:** ☐AO/Parole Staff ☐DCF ☐DDS Case Manager ☐Family/Guardian ☐Member ☐Milieu Staff ☐Medical ASO ☐Outpatient Provider ☐Peer/FPS ☐Psychiatrist/Nurse ☐School ☐LMHA (if managed by)

***Is there a child or adult in member's household in need of any support or service:** ☐Yes ☐No

If Yes, select primary support/services needed: ☐Behavioral Health ☐Medical ☐Social Services ☐Transportation ☐Housing

If Yes, describe the support/service that is recommended: _____

_____

***Is service requested for HLOC because appropriate LLOC is not available:** ☐Yes ☐No

If Yes, what LLOC was needed and not available for the member: ☐Crisis Stabilization ☐Obs. Bed

☐IICAPS ☐MST ☐MDFT ☐FFT ☐FST ☐Therapeutic Mentoring
☐PHP ☐IOP ☐EDT ☐Home Visit ☐Home Health ☐Psych Testing
☐Meth. Maintenance ☐EPSDT ☐Outpatient ☐RTC ☐Group Home
☐SA Rehab ☐PRTF ☐Other _____

If Yes, what is the reason why appropriate LLOC is not available: ☐Does not exist in geographic area
☐At capacity/no openings ☐Does not provide specialty needed ☐Member Declined
☐Hours not Available ☐Determine Not Crisis ☐Family Decline
☐Other _____

Discharge Information:

***Planned discharge Level of Care:** ☐Community Support Team ☐Outpatient ☐Respite
☐Targeted Case Management ☐Inpatient ☐23 Hour ☐CSU ☐Partial Hospitalization
☐Residential Treatment Center ☐Group Home ☐Halfway House ☐Day Services ☐IOP/SOP
☐Alternative ☐Community Support ☐Day Treatment ☐Foster Care ☐In-Home Family Services
☐Placement Services ☐PRTF ☐Residential Child Care ☐Specialty Children's Programs ☐Subacute
☐Assertive Community Treatment ☐Facility Based Crisis ☐Intensive In-Home ☐Other _____

***Planned Discharge Residence:** ☐AWOL ☐Correctional Facility ☐Foster Home
☐Group Home (non therapeutic) ☐Group Home Pass ☐Group Home (therapeutic)
☐Home ☐Independent Living ☐Juvenile Detention ☐Nursing Home/SNF/Assisted Living
☐PRTF Community ☐PRTF Solnit ☐RTC ☐State Hospital
☐Supervised/Supportive Housing ☐Therapeutic Foster Care ☐Transfer to Alt. Psych or Rehab Facility
☐Transfer to Medical ☐Unknown ☐Other _____

***Expected Discharge Date:** *(only required on concurrent reviews)* _____