PerformCARE®

ADULT LONG TERM PARTIAL HOSPITALIZATION PROGRAM
TX REQUEST SUBMISSION FORM

Member Name:

DOB: **MAID:**

FOR DISCHARGES, PLEASE SKIP TO DISCHARGE PORTION AND COMPLETE ALL SECTIONS.

CONTINUED STAY REVIEW

Date: Provider Site:

Person submitting form/Credentials:

Contact Number/Extension:

Dates Requested for Authorization: (to) Please ensure dates are on weekdays.

Number of Days Requested (Ex: 30, 60, 90, Other):

Scheduled Days and Hours/Week Hrs/Day: Days/Week:

DIAGNOSIS (Include ICD 10 code, Written Psychiatric Diagnosis, and Medical Diagnosis)

MEDICATIONS Adherence: (Y/N) Barriers:

Rationale for Med Changes:

PSYCHOTROPIC – NAME/DOSE/FREQ/DATE OF LAST CHANGE/RECENT LEVEL/DATE
Rationale for Med Changes:

Prescribing Physician:

MEDICAL – NAME/DOSE/FREQ/DATE OF CHANGE/RECENT LEVEL/DATE: Rationale for Med Changes:

Prescribing Physician:

Adherence: (Y/N) Barriers:

Plan to address barriers:

Rationale for Med Changes:

SUBSTANCE ABUSE

Current/Recent use of substances: (Y/N)
History of Use: (Y/N)

SUBSTANCE/ROUTE: (Oral/IV/Nasal/Smoking/Sublingual): AMT/FREQ: FIRST USE: LAST USE:

Current SA TX:

Planned SA Tx:

Barriers:

Plan to address barriers:

TRAUMA/ABUSE/GRIEF AND LOSS

History:

Was Abuse Reported: (Please elaborate)

Any New Disclosure: (If Yes, please elaborate)

Was Abuse Reported: (Y/N) Date Reported:

Current Tx:

Planned Trauma Tx:

Barriers:

Plan to address barriers:

CURRENT MENTAL/FUNCTIONAL STATUS/LIVING ENVIRONMENT:

MEMBER DRIVEN GOALS (Limit to 3 – Please Update)

1) Goal:

Action Steps:

Progress:

Barriers:

Plan to address:

2) Goal:

Action Steps:

Progress:

Barriers:

Plan to address:

3) Goal:

Action Steps:

Progress:

Barriers:

Plan to address:

CULTURAL/LANGUAGE/SPECIAL NEEDS IMPACTING TX:

Measures to address:

FAMILY PSYCHIATRIC HISTORY:

FAMILY AND NATURAL INVOLVEMENT/CONTACT

Involved Family/Natural Supports: (Please list)

Last Contact:

Barriers:

Plans to address:

PREVENTION PLAN

Relapse Triggers:

Warning Signs:

Coping Skills:

Member Identifies Strengths As:

Measures to Utilize Strengths:

If Member cannot identify strengths, what steps are being taken to assist member to identify?

Natural Supports:

Community Supports:

Recovery Focused Support or Referral made:

Does member have a WRAP Plan? (Y/N)

If no, was WRAP explained to member and referral made for Peer Support per member agreement?

Does Member's WRAP Plan match Prevention Plan?: (Y/N)

Member Crisis Plan: (Please Update)

CURRENT TREATMENT ADHERENCE

Barriers:

Plans to Address:

COORDINATION OF CARE: Please list Provider, Contact, Phone/Ext, and Last Contact for any professional involvement outside of PHP including PCP, Specialist

CASE MANAGEMENT: Please identify Level of Case Management (Admin, RC, ICM/BCM), (Include Name, Agency, Phone/Ext.)

Date of last contact and plan:

<u>DISCHARGE PLAN</u> (Aftercare Planning starts at Admission – asking for PHP's evolving recommendations for aftercare services prior to member's anticipated discharge.)

MEMBER'S CURRENT ADDRESS/PHONE NUMBER:

PROFESSIONAL SUPPORTS: (Level of Care, Provider Name/Site, Contact Number, Appt. Date/Time)

RECOVERY FOCUSED SUPPORTS: (Indicate Type, Provider, Contact)

INFORMAL SUPPORTS: (Type, Name, Contact Number)

ANTICIPATED D/C DATE:

SIGNATURE OF PERSON COMPLETING FORM:
DATE:

DISCHARGE REVIEW ONLY

MEMBER NAME:

DOB: **MAID:**

Date: Provider Site:

Person Submitting Form/Credentials:

Contact Number/Extension:

DISCHARGE DATE:

DISCHARGE TYPE: (Completion of Treatment, AMA, Withdraw From Tx, Other)

If treatment was not completed, please identify rationale:

PHP Staff Follow-up/Outreach:

DIAGNOSIS: (Include ICD 10 code, Written Psychiatric Diagnosis, and Medical Diagnosis)

MEDICATIONS: Adherence: (Y/N) Barriers:

Rationale for Med Changes:

PSYCHOTROPIC – NAME/DOSE/FREQ/DATE OF LAST CHANGE/RECENT LEVEL/DATE:

Rationale for Med Changes:

Prescribing Physician:

MEDICAL – NAME/DOSE/FREQ/DATE OF CHANGE/RECENT LEVEL/DATE:

Rationale for Med Changes:

Prescribing Physician:

AFTERCARE

PROFESSIONAL SUPPORTS: (Level of Care, Provider Name/Site, Contact Number, Appt. Date/Time)

RECOVERY FOCUSED SUPPORTS: (Indicate Type, Provider, Contact)

INFORMAL SUPPORTS: (Type, Name, Contact Number)

PREVENTION PLAN: (Triggers, Warning Signs, Crisis Plan)

MEMBER'S CURRENT ADDRESS/PHONE NUMBER:

SIGNATURE OF PERSON COMPLETING FORM:
DATE: