AD 14 102B
Attachment
HEALTHCHOICES SUBSTANCE ABUSE ASSESSMENT

Initial Substance Abuse Assessment
CCM Name, Date and Time Request Received:
MEMBER (MBR) IS DESIGNATED AS HIGH RISK: (Yes/No)
LOC BEING PRECERTED: (SA 2B, 3A, 4A, 3B, 4B, 3C):

DIAGNOSIS:

TREATMENT HISTORY
Previous MH/SA IP:
Is this admission a readmission within 30 days: **(Yes / No)**
Current MH/SA Treatment: (**Yes / No).**
If yes, current provider notified of admission? **(Yes / No / NA)** Is the mbr compliant with tx? **(Yes / No)**
If no, did CCM request that provider notify treatment provider of the hospitalization? **(Yes / No / NA)**

Dimension 1: WITHDRAWAL/ACUTE INTOXICATION:
(Please complete for each substance used)
Substance Used & route (oral/IV/snort, etc):
Pattern of use:
Age Started Using:
Last Used:

Substance Used & route (oral/IV/snort, etc):
Pattern of use:
Age Started Using:
Last Used:

Substance Used & route (oral/IV/snort, etc):
Pattern of use:
Age Started Using:
Last Used:

Substance Used & route (oral/IV/snort, etc):
Pattern of use:
Age Started Using:
Last Used:

Hx of withdrawal symptoms:
Current withdrawal symptoms:

Dimension 2: Biomedical Complications:
Current Medical Issues not identified in diagnosis:
Seizure History:
Relevant Medical Medications:

Dimension 3: Emotional/Behavioral Complications:
Current Psychotropic Medications:
Is member adherent with medications: (Yes / No) If no, barriers to adherence:
Current Mental Health Symptoms:
History of trauma/abuse:

Is mbr able to complete ADL's: (Yes/No): If no, explain:

Dimension 4:Treatment Acceptance/Resistance:
Member motivation for treatment:

Dimension 5: Relapse Potential/Continued Problem Potential:
Current assessed relapse risk level: **(High / Moderate / Low)**

Dimension 6: Recovery/Living Environment:
Sober support system:
Issues that impede recovery:
Are there Cultural/Language Preferences that impact treatment: **(Yes / No)**

Preliminary Discharge Plan

Residence:
Treatment:
Provider:

Exploration of diversion options (are/are not) appropriate based on clinical needs
DIVERSION (Complete only if diversion is a clinically appropriate option)
Diversion Discussion:
Housing Status impacting diversion:
Guardian/Power of Attorney impacting diversion:
Assessment of community based alternatives/supports:
Psychiatric Advanced Directives impacting diversion:
Barriers to Discharge/Aftercare: **(Yes / No)**. If yes, explain

PCPC/ASAM DETERMINATION:
Is a PA Consult Needed:
Name of PA Consulted:
Reason for PA Consult:
If PA Consult, PA Comments/Direction:
If LOC denied by PA, was member notified of denial and grievance rights:
If LOC approved by PA, symptoms meeting criteria:
Staff Name, Credentials and Time Review Completed:

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SA Continued Stay Review
CCM NAME, DATE, and TIME REQUEST RECEIVED:
Diagnosis:

Dimension 1: Acute Intoxication and/or Withdrawal Potential:
Ongoing withdrawal symptoms:

Dimension 2: Biomedical Conditions and Complications:
Current Medical Issues not identified in Diagnosis:
Current Medical Medications:
PCP/SNU/PH-MCO referral needed:

Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications:
Current Psychotropic Medications:
Is member adherent with medications: (Yes / No) If no, barriers to adherence:
Current risk factors / Clinical Update:

Dimension 4: Readiness to Change:
Member motivation for treatment:

Dimension 5: Relapse, Continued Use or Continued Problem Potential:
Current assessed relapse risk level: **(High / Moderate / Low)**
Relapse Triggers:

Dimension 6: Recovery/Living Environment:
Complex Case Management involvement/referral:
Outreaches made by provider for collaboration:
Family/Natural Support Involvement:
Are there Cultural/Language Preferences that impact treatment: **(Yes / No)**
Recovery Plan:
Discharge Plan and Barriers:

SUMMARY OF UM RECOMMENDATIONS:
UM Concerns including QOCC and Provider Performance:

PCPC/ASAM DETERMINATION:
LOC Approved:
Is a PA Consult Needed:
Reason for PA Consult:
If PA Consult, PA Comments/Direction:
If LOC denied by PA, was member notified of denial and grievance rights:
If LOC approved by PA, symptoms meeting criteria:
Staff Name, Credentials and Time Review Completed:

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Discharge Review

CCM Name, Date, and Time:

Date of Discharge:

Is mbr returning to address listed in eCura: (Yes/No): If no, discharge address:

Phone:

Guardian/Parent Name, if applicable:

Discharge Psychotropic Medications and Dosages:

Discharge Diagnoses:

Safety/Crisis Plan:

Are there any identified barriers in the aftercare plan that require follow up? (Yes / No)
If yes, explain barrier and plan:

Aftercare Appointments Not Identified in Ecura:

Quality of Care Concerns:
Staff Name, Credentials and Time Review Completed: