Texas Children's Health Plan
The best decision a family can make.

Texas Children's Health Plan Behavioral Health Authorization Form

FAX to: 832-825-8767

Date of admission___ /___/___ **Time of admit**__________
Requested start date for this authorization ____/____/____
Level of care: ☐ Inpatient ☐ Partial ☐ RTC ☐ IOP ☐ OP Codes: ______________
Type of review: ☐ Initial ☐ Concurrent ☐OP Number of visits: _______________
Type of care: ☐ Rehabilitation ☐ Detoxification ☐ Psychiatric
Precipitating event or concurrent clinical
____
____
____
____

Patient's current location: ☐ ER ☐ Jail ☐ Detention ☐ Provider's Office ☐Home
Demographics: ☐**Male** ☐**Female**
Patient's Name ________________________ **Date of Birth:** _______________
Medicaid: ☐ **Yes** ☐ **No** **CHIP:** ☐ **Yes** ☐ **No** **Age:** ________________
Member ID#: _________________________ **Tel #:** __________________
Guardian:____
Address: ____
City/State/ZIP:____

Facility
Name: __________________________Attending:_________________________
Address/City/St: ____
UR Contact: ____________________________**Tel** ___________________
Fax___________________

DSM IV-TR
Axis I : a.) _________________________ b.)_________________________
Axis II: a.) _________________________ b.)_________________________
Axis III: a.)_________________________ b.)_________________________
Axis IV: ____
Axis V: Current GAF: _____________ Highest GAF prev. year: ____________

Current Risks: *Risk Level Scale: NA=not assessed/not applicable. 0=none, 1-mild, ideation only; 2=moderate, ideation with EITHER plan or history of attempts; 3=severe, ideation AND plan, with either intent or means;*
Circle risk level for each category and check all boxes that apply:
Risk to self (SI): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA ☐ Ideation ☐ Means ☐ Plan ____________
Risk to others (HI): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA ☐ Ideation ☐ Means ☐ Plan __________
Current serious attempts: ☐ Yes ☐ No ☐ SI ☐ HI _____________________________
Prior serious attempts: ☐ Yes ☐ No ☐ SI ☐ HI How many: __________
Prior serious gestures: ☐ Yes ☐ No ☐ SI ☐ HI How many: __________
Date of the most recent attempt or gesture: ____/____/_____

Current Impairments: Scale 0=none, 1=mild, 2=moderate, 3=severe, NA=not assessed
List Details on line:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Mood Disturbance (Depression or mania)________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Sleep disturbance (specify) ______________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Hypo mania/mania ___________________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Lack of interest ___________________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Grandiosity ______________________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Sexuality _______________________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Concentration/Inattention___________________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Impulsivity_________________________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Irritability/Frustration_____________________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Anxiety __________________________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Psychosis_________________________________
Hallucinations Visual ☐ Olfactory ☐ Auditory ☐ Tactile
Paranoid☐ Yes ☐ No If Yes List: ___________________________
Delusional☐ Yes ☐ No If Yes List: __________________________
Thought disorder/Insertion/ broadcasting ☐ Yes ☐ No If Yes List:______________
Disorganized☐ Yes ☐ No If Yes List:___________________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Thinking/Cognition/Memory/Orientation List:______________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Activities of Daily Living List:__________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Weight Change Assoc. w/Behavioral Dx ☐ Yes ☐ No ☐ NA _______
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Medical/Physical Condition(s) account for symptoms? __________

Laboratory testing done ☐ Yes ☐ No ***(If yes attach results)***
Test performed: ☐ HIV ☐ TB ☐ Hepatitis ☐ STD ☐ Pregnancy ☐ Drug ☐ Other _____
Result:____
Physical exam: ☐ Yes ☐ No Height - ______ft. _____ in. Weight ______ lbs **BMI:** ______

Current Psychotropic Medications: ☐ **None**

Medication(s)	**Dose/Freq** 10mg/QAM	**Date**	**Increased/ Decreased**	**Com pliant** Y or N

Substance Use/Abuse:

Substance	**Length current use**	**Amount**	**Frequency**	**Date last used**

Family history of psychiatric, mental, neurological or substance abuse/dependence obtained?
☐ Yes ☐ No If Yes list: ______________________________________
School performance ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA
Failed ☐ Suspended ☐ Expelled ☐ Other list ____________________________
Social history
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Social/Marital/Family Problems - list ________________
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ NA Legal - list ________________________________
Other history:
Criminal justice involvement in the last 12 months? ☐ Yes ☐ No; Yes list: ____________
Currently on probation: ☐ Yes ☐ No List: ______________________________
History of sexually inappropriate/aggressive behavior? ☐ Yes ☐ No; Yes list:___________
History of fire setting in the last 12 mos? ☐ Yes ☐ No; Yes list: _________________
Active gang involvement in the last 12 mos? ☐ Yes ☐ No; Yes list: ________________
CPS involvement in the last 12 -36 mos? ☐ Yes ☐ No; Yes list:___________________
Victim of sexual or physical abuse? ☐ Yes ☐ No List:_________________________

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MENTAL HEALTH TREATMENT HISTORY

Outpatient mental health/psychiatric treatment: ☐ Yes ☐ No
If *"Outpatient" is checked, please indicate outcome:*
☐ Unknown Outcome ☐ Improved ☐ No Change ☐ Worse ___________________________
Compliance ☐ Unknown ☐ Poor ☐ Fair ☐ Good ___________________________________

Intensive outpatient/ SOP mental health treatment: ☐ No ☐ Yes:
If *"IOP/Partial" is checked, please indicate: outcome:*
☐ Unknown Outcome ☐ Improved ☐ No Change ☐ Worse ___________________________
Compliance ☐ Unknown ☐ Poor ☐ Fair ☐ Good ___________________________________

Inpatient/residential/group home mental health treatment: ☐ No ☐Yes
If *"Inpatient/Residential" is checked, please indicate outcome:*
☐ Unknown Outcome ☐ Improved ☐ No Change ☐ Worse __________________________
Compliance ☐ Unknown ☐ Poor ☐ Fair ☐ Good ___________________________________

Number of psychiatric hospitalizations in the past 12 months: _______________________

Substance abuse treatment history: ☐Yes ☐ No ☐ Unknown

Did they receive outpatient IOP/SOP? ☐Yes ☐ No
If they received "Outpatient IOP/SOP" please indicate outcome:
☐ Unknown Outcome ☐ Improved ☐ No Change ☐ Worse __________________________
Compliance ☐ Unknown ☐ Poor ☐ Fair ☐ Good ___________________________________

Did they receive partial hospitalization treatment? ☐Yes ☐No
If they "Partial" is checked, please indicate outcome:
☐ Unknown Outcome ☐ Improved ☐ No Change ☐ Worse __________________________
Compliance ☐ Unknown ☐ Poor ☐ Fair ☐ Good ___________________________________

Did they receive inpatient/residential/group home? ☐Yes ☐ No
If "Inpatient/Residential" is checked, please indicate outcome: ☐Unknown
☐Improved ☐ No Change ☐ Worse
Inpatient/Residential Treatment compliance? ☐Unknown ☐Poor ☐Fair ☐Good
Number of substance abuse hospitalizations in the past 12 months? _________________

Longest period of sobriety: ☐<6 mo. ☐6 mo. ☐2 yrs ☐2+yrs ☐ None ☐ Unknown
Relapse Date: ____/____/____

Withdrawal symptoms: *Check all that apply.*
☐ None ☐ Nausea ☐ Sweating ☐ Tremors ☐ Past DTs ☐ BR or Pulse evaluation ☐ Vomiting
☐ Agitation ☐ Disorientation ☐ Current seizures ☐ Cramping ☐ Hallucinations ☐ Current DTs
☐ Past Seizures ☐ Diarrhea
Indicate if using the CIWA-R, OWA or other ___________ instrument to monitor?

Detoxification: Vitals BP_______ Temp: ______ Pulse: ________ RR: _______ BAL: _______

UDS: N Date: _______ If positive, for what? ______________________________________

For Substance Abuse Treatment Only select the ASAM level and dimension:
ASAM Levels of Care:
☐ Level 0.5: Early Intervention ☐ Level III: Residential/Inpatient Treatment
☐ Level I: Outpatient Treatment ☐ Level IV: Medically-Managed Intensive Inpatient Treatment
☐ Level II: Intensive Outpatient/Partial Hospitalization

CM-0513-132

ASAM Patient Placement Dimensions:

1. Intoxicated/WD Potential ☐ Lo ☐ Med ☐ Hi 2. Biomedical Conditions ☐ Lo ☐ Med ☐ Hi
3. Emot/Beh/Cog Conditions ☐ Lo ☐ Med ☐ Hi 4. Readiness to Change ☐ Lo ☐ Med ☐ Hi
5. Relapse Potential ☐ Lo ☐ Med ☐ Hi 6. Recovery Environment ☐ Lo ☐ Med ☐ Hi

Treatment request: admit date: ____/____/____ Requested visits___days___
Is family/individual therapy indicated? ☐ Yes ☐ No If yes, date of appt. ___/____/____
☐ Involuntary ☐ Court Ordered ☐Fixed Length Program (Specify length :___________)
Frequency of program = __________________ per ____________________________________

Reason for continued stay: ☐ Remains symptomatic ☐ Pending med level
☐ Stabilize medications ☐ Has not achieved treatment goals ☐ Other____________________

Barriers to discharge: ☐ Discharge treatment setting not available ☐ Transportation
☐ Legal Mandate ☐ Adequate Housing/Residence ☐ Lack of Community Support
☐ Treatment Non-Compliance ☐Other ____

Discharge Plan:
Expected D/C Date if known: ___/___/___
Planned D/C Level of Care: ☐ Outpatient ☐ Inpatient 23 hr ☐ CSU ☐ RTC ☐ Partial IOP/SOP
☐ Group Home ☐ Halfway House ☐ Other ____

Planned living arrangements: ☐ Post D/C Residence ☐ Home (Alone or w/others)
☐ RTC/Group Home/Halfway House Shelter ☐ Correctional Facility ☐ Foster Care ☐ Respite
☐ State Hosp. ☐ Residential ☐ Juvenile Detention ☐Transfer to Medical ☐ Transfer to
Alternate Psych. Facility ☐ Other ____

Discharge Planning
Contact Person Tel. #: ____

Contact Person Name: ____

I acknowledge this facility and referring provider are aware of the requirement for 7 and 30-day follow-up post discharge from an inpatient or RTC facility. The parent/guardian have been informed and acknowledged the follow up requirement.

Signed____

Comments ____

ADDITIONAL AREA FOR CLINICAL INFORMATION:

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