Mailing Address:
P.O. Box 1309
Minneapolis, MN 55440-1309
Mailstop 21103M

Chemical Health Authorization Request Form for Residential Level of Care Date: _____

Fax to: coOportunityHealth at 952.853.8830, BH Triage line: 1.866.669.3856

coOportunityHealth CANNOT accept a completed form via e-mail. Can only accept via fax or US mail.

Requesting Provider Contact		
Name: Address:	Facility: Person completing this form:	Tel#: Fax#:

Member Information		
Name:	DOB/Age:	Member #:
Address:	Phone:	Cell: Work:
Ethnicity:	Relationship status:	Education level:

Reason for seeking assessment /treatment:

Diagnosis
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Dimension 1: Acute Intoxication and/or Withdrawal	**Risk Level:**

Will this member require detox services? * Yes * No
Has the member ever been in detox before? If so where and when?

CoOportunity Health has contracted with HealthPartners Administrators, Inc to provide claims processing, medical management and certain other administrative services.

Current Withdrawal Symptoms:

* Insomnia/Excessive sleep * Nausea/vomiting * Sweating * Rapid pulse * Fatigue * High BP
* Loss/increased appetite * Depression * Muscle aches * Anxiety * Delirium (DTs)
* Irritability/Agitation * Hallucinations * Dizziness * Seizures * Fever
* Psychosis/unreal feelings * Diarrhea * Tongue Tremors * Other _____

History of Withdrawal Symptoms Currently not Present:

* Insomnia/Excessive sleep * Nausea/vomiting * Sweating * Rapid pulse * Fatigue * High BP
* Loss/increased appetite * Depression * Muscle aches * Anxiety * Delirium (DTs)
* Irritability/Agitation * Hallucinations * Dizziness * Seizures * Fever
* Psychosis/unreal feelings * Tongue Tremors * Diarrhea * Headache * Other _____

Symptoms of use:

* Increased tolerance * Decreased tolerance * Use to intoxication * Passing out from use
* Morning use * Hurried ingestion * Mood Swings * Black outs – How often? _____
* Using alone * Loss of control * Preoccupation * Binges
* Medicinal use * Cravings * Other _____

Chemical Use:

Chemical use history including:

Drug	How much	How often	Date of last use

Drug of choice:

Does member have history of IV drug use?

Dimension 2: Biomedical Conditions and Complications Risk level:

Primary Care Clinic and doctor:

Phone #: Date last seen:

Current Medical concerns:

Current Medications:

Prior Medical Concerns:

Prior Hospitalizations:

Physical Disabilities:

Dimension 3: Emotional, Behavioral or Cognitive Conditions/Complications Risk level:

Past hospitalized for emotional/mental health issues:

Current MH diagnosis/symptoms:

Has the member ever take medications for emotional /psychiatric problems?

Current meds and what they are prescribed for:

Current Psychiatrist name and phone number:

Current therapist's name and phone number:

History of verbal, emotional, sexual or physical abuse:

Family history of emotional/mental health issues:

History of learning disabilities or cognitive issues:

Can the member read and write?

Has the member ever attempted suicide?

Have they considered suicide recently (if yes, is there a current plan or intent?

History of self-injurious behavior?

Is the member able to care for himself?

Is the member a danger to them self or others?

Other addictive or compulsive behaviors:

Dimension 4: Readiness to Change **Risk Level:**

Prior treatments including when, where, type of treatment (outpatient, IOP, residential, inpatient), length of stay, length of sobriety and did the member complete?

Date	Type of Treatment	Clinic / Facility	Length of stay	Did member complete treatment?	Length of sobriety after treatment

Barriers to treatment:

Motivation for treatment:

Does the member believe they are chemically dependent? Why or why not?

Is the member able to identify their consequences of use?

History of AA / NA / Self-help groups:

Current/Past Legal issues:

Date	Offense / Charges	BAC	Outcome

Is the member on probation?

If so, name and number of probation officer:

Pending court dates:

Dimension 5: Relapse, Continued Use or Continued Problem Potential Risk Level:

Member's longest period of sobriety:

If relapsed before, what happened?

How does the member cope with stress?

Is the member experiencing drug cravings? If so, how?

Is the member involved in drug trafficking or gang related activity?

What support does the member have from his peers?

Is the member a danger to himself or others? If so how?

Dimension 6: Recovery Environment Risk level:

Family

Current living situation (with whom?):

Number of children/ages and names:

Family background (hx of chemical use with parents, siblings, spouse, children, etc):

Are family member's supportive of the member's recovery? (If yes, whom?)

Past or current violence or abuse (physical, sexual emotional) in the home – describe:

Does the member feel safe in their home?

What are the member's leisure activities?

Occupation/Financial **Current occupation:**

Is the member employed? (If so where and for how long)?

What is their work history for the last 7 years?

Haw has work been affected by the member's use?

If not working, how is the member supported financially?

How much does the member spend on chemicals per week?

Social Network

Does the member have friends that are supportive of their recovery?

Does the member use with friends?

Does the member use alone?

Is the member involved in drug dealing/trafficking?

CD Professional's Level of Care Determination Based on Assessment Results:

*** Abstinence/AA * Outpatient * IOP * IOP w/Lodging * Residential * Inpatient/Detox**

Program Requested by Member: (Authorization is subject to criteria, member's benefit plan & contractual obligations)