Select Health of South Carolina

Healthy Connections

Behavioral Health Fax Form

Inpatient and Substance Use Disorders Treatment Services

When complete, please fax to **1-888-796-5521**.

Today's date: _____ Start date of admission/service: _____

Type of review	**Type of admission**	**Admission status**	**Estimated length of stay:**
☐ Precertification	☐ IOP ☐ Substance abuse:	☐ Voluntary commitment	(days/units)
☐ Continued stay	☐ MH-IP ☐ Detox	☐ Involuntary commitment	**Re-admission within 30 days?**
☐ Discharge	☐ PHP/Day treatment ☐ Rehab		☐ Yes ☐ No

Note: For free-standing psychiatric facilities, a Certificate of Need is required for children under the age of 21..

Member information

Member name (Last, First, MI)	
Eligibility ID #	Date of birth
Member address	
Emergency contact (other than primary caregiver)	Phone
Legal guardian/parent	Phone

Provider information

Facility/Provider name	NPI #/Tax ID
Attending MD	Provider ID
Facility/Provider address	
UM review contact	Phone
DSM-5 Diagnoses (include mental health, substance abuse & medical)	

Medications

Medication name	Dosage	Frequency	Date of last change	Type of change
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
Additional information				

Presenting Problem/Current Clinical Update (Include SI, HI, psychotic, mood/affect, sleep, appetite, withdrawal symptoms, chronic SA)

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Page 2 of 2 for member name: _____ Eligibility ID number: _____

Treatment History and Current Treatment Participation

Previous MH/SA inpatient, rehab or detox:
Outpatient treatment history:
Is the member attending therapy and groups? ☐ Yes ☐ No If yes, please specify:
Explain clinical treatment plan:
Family involvement and/or support system:

Substance Abuse: ☐ Yes ☐ No

If yes, MH services only, please explain how substance abuse is being treated:
If yes, please complete below for current ASAM dimensions and/or submit with documentation for SA IOP, PHP/Day Treatment, SA Detox and SA Rehab.

Dimension Rating (0-4)	Current ASAM Dimensions are Required			
Dimension 1: Acute intoxication and/or withdrawal potential Ranking:	Substances used (pattern, route, last used):	Tox screen completed? ☐ Yes ☐ No If yes, results:	History of withdrawal symptoms:	Current withdrawal symptoms:
Dimension 2: Biomedical conditions and complications Ranking:	Vital signs:	Is member under doctor care? ☐ Yes ☐ No Current medical conditions:	History of seizures? ☐ Yes ☐ No	
Dimension 3: Emotional, behavioral or cognitive conditions and complications Ranking:	MH diagnosis:	Cognitive limits? ☐ Yes ☐ No	Psych medications and dosages:	Current risk factors (SI, HI, psychotic symptoms, etc.):
Dimension 4: Readiness to change Ranking:	Awareness/commitment to change:	Internal or external motivation:	Stage of change, if known:	Legal problems/probation officer:
Dimension 5: Relapse, continued use or continued problem potential Ranking:	Relapse prevention skills:	Current assessed relapse risk level: ☐ High ☐ Moderate ☐ Low	Longest period of sobriety:	
Dimension 6: Recovery/living environment Ranking:	Living situations:	Sober support system:	Attendance at support group:	Issues that impede recovery:

Discharge Planning

Discharge planner name:	Discharge planner phone:
Residence address upon discharge	
Treatment setting upon discharge	Treatment provider upon discharge
Has a post-discharge 7-day follow-up appointment been scheduled? ☐ Yes ☐ No	
If no, please explain:	
If yes, give treatment provider name and date/time of scheduled follow up: