Network Health Plan Outpatient Treatment Request for AODA Services - Concurrent

Please complete and fax this form to NHP (920) 720-1903 for commercial members and (920) 720-1916 for Medicare members.
Address: Behavioral Health Care Management Department Network Health Plan 1570 Midway Place Menasha, WI 54952
Provider questions: (920) 720- 1340 or (800) 555-3616

Member Name:		Date of Birth:		Age:	
Therapist Name:		Facility:			
Phone Number:		Fax Number:			
Substance(s) of Abuse:		Axis I Diagnosis:			

Check all services provided in the last month:

- ☐ Clinical assessment
- ☐ Psychiatric/medication eval
- ☐ Substance evaluation
- ☐ Tox screen/breathalyzer
- ☐ Behavioral contract
- ☐ Goal-directed treatment plan
- ☐ 12-step/self-help group-suggested
- ☐ Ind/group/fam therapy _____x week
- ☐ education group _____x week
- ☐ Other: _____

Symptoms/Behavior: Check all that apply within the last month:

- ☐ Preoccupation with getting high
- ☐ Preoccupation with past drugging experiences
- ☐ Drug glorification
- ☐ Reckless/impulsive behaviors
- ☐ Nonresponsive to interventions
- ☐ Drug seeking
- ☐ Frequent mood swings
- ☐ Failure to maintain abstinence
- ☐ Self-mutilation
- ☐ Guilt/remorse/shame
- ☐ Irritability
- ☐ Psychosis
- ☐ Labile mood
- ☐ Anxious
- ☐ Depressed

Functional Impairments: Check all that apply within the last month:

- ☐ Socially withdrawn
- ☐ Verbal warning school/work
- ☐ Written warning school/work
- ☐ Unable/unwilling to ask for help
- ☐ Unable to develop sober support
- ☐ Decreased productivity
- ☐ After hours crisis intervention
- ☐ Difficulty engaging in treatment
- ☐ Easily manipulated by peers
- ☐ Interpersonal conflict
- ☐ Social isolation/alienation
- ☐ Poor/intrusive boundaries
- ☐ No positive connections
- ☐ Inadequate coping skills
- ☐ Requires monitoring
- ☐ Enabling support system
- ☐ Marginal positive connection
- ☐ Requires reinforcement
- ☐ Pregnancy
- ☐ Co-occurring medical condition
- ☐ Co-occurring psychiatric condition
- ☐ Poor impulse control
- ☐ Change in hobbies/activities
- ☐ Absences from school/work
- ☐ Difficulty caring for dependents
- ☐ Housing concerns
- ☐ Good impulse control
- ☐ Decreased social contacts
- ☐ Nonverbal or hostile interactions
- ☐ Threatening or accusatory
- ☐ Occasional arguments
- ☐ Relationships termed or strained
- ☐ Abused/Abusive

Adherence to Current Treatment: Check all that apply within the last month:

- ☐ Attendance at least 80%
- ☐ Identifies goals
- ☐ Identifies sober supports
- ☐ Identifies triggers
- ☐ Engages in treatment milieu
- ☐ Engages with positive peer group
- ☐ Attends community/self-help group
- ☐ Unable to adhere to treatment
- ☐ Other_____

Requested Treatment:

Requesting: ☐ Partial Hospital (PH) ☐ Intensive Outpatient (IOP) ☐ Outpatient

If requesting PH/IOP please complete: sessions meet for _____hours_____days a week for _____weeks.

Requesting _____sessions Requested Auth Start Date:_____

Signature:_____ **Date**:_____

For NHP Use:
Authorization #:_____ _____additional sessions authorized from_____until_____

NHP Staff Signature:_____.

Revised: July 2010