

## Network Health Plan Outpatient Treatment Request for AODA Services - Initial

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:			
Assessment Date:		Axis I Diagnosis:			
Substance(s) of Abuse:		Amt/Freq of use:		Date of Last Use:	
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**Safety Risk: Check all that have occurred in the last week:**

- |                                                                                   |                                                            |
|-----------------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Suicidal/homicidal ideation                              | <input type="checkbox"/> Arrest/confirmed illegal activity |
| <input type="checkbox"/> Family/Intimate partner violence                         | <input type="checkbox"/> Change in appearance/self-care    |
| <input type="checkbox"/> Psychotic symptoms                                       | <input type="checkbox"/> Self mutilation                   |
| <input type="checkbox"/> Increased irritability/angry outbursts                   | <input type="checkbox"/> Found with drugs/paraphernalia    |
| <input type="checkbox"/> Unexplained injury/accident/fall                         | <input type="checkbox"/> Amnesia or blackout               |
| <input type="checkbox"/> Lying, manipulating drug seeking behavior                | <input type="checkbox"/> Reckless/impulsive behavior       |
| <input type="checkbox"/> At risk of loss of: (residence? health? license?) _____. |                                                            |

**Functional Impairment: Check all that have occurred in the last month:**

- |                                                                      |                                                                     |
|----------------------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Withdrawn                                   | <input type="checkbox"/> Decreased social contacts                  |
| <input type="checkbox"/> Nonverbal or hostile                        | <input type="checkbox"/> Threatening or accusatory                  |
| <input type="checkbox"/> Occasional arguments                        | <input type="checkbox"/> Relationships termed or strained           |
| <input type="checkbox"/> Change in credit use                        | <input type="checkbox"/> Cult or gang activity                      |
| <input type="checkbox"/> Negative or using peers                     | <input type="checkbox"/> Change in school or work productivity      |
| <input type="checkbox"/> Change in care of dependents                | <input type="checkbox"/> Easily manipulated by peers                |
| <input type="checkbox"/> Actual/perceived target of social rejection | <input type="checkbox"/> Absences from school or work               |
| <input type="checkbox"/> Received warning from school/employer       | <input type="checkbox"/> Abused/Abusive (emotional/physical/sexual) |
| <input type="checkbox"/> Inadequate coping skills                    | <input type="checkbox"/> Residence/support system issues            |
| <input type="checkbox"/> Change in hobbies/activities                | <input type="checkbox"/> Other impairment: _____.                   |

**Treatment History:**

- Prior treatment                       No prior treatment

Dates: \_\_\_\_\_ type: \_\_\_\_\_ location: \_\_\_\_\_.

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**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: \_\_\_\_\_

Compliance:     expected to adhere                       agrees with treatment                       unable or unwilling

**Signature:** \_\_\_\_\_                      **Date:** \_\_\_\_\_.

For NHP Use: Authorization #: _____	_____ sessions authorized from _____ until _____
Authorization Valid: _____	NHP Staff Signature: _____