PreferredOne®

Out of Network Eating Disorder Authorization Form

This form must be filled out in addition to Minnesota's Universal Outpatient Mental Health/Chemical Health Authorization Form for an eating disorder treatment.

Member's Name: _____

Member's ID: _____

Level of care _____ **Days per week:** _____ **Hours per day:** _____

Target problems/symptoms: **Weight:** ____ **Height:** _____ **BMI:** _____

Vitals:
Temperature: _____

BP Supine: _____ **Pulse Supine:** _____

BP Standing: _____ **Pulse Standing:** _____

Medical complications (abnormal lab, dehydration, etc.):_____

_____

_____

Eating disorder thoughts (fear of eating certain foods, body image, fear of weight gain, etc.) with frequency and duration: _____

_____

_____

Eating disorder behaviors (restricting, bingeing, purging, taking replacements, compulsive exercise, etc) with frequency and duration:_____

_____

_____

Meal plan: _____

Barriers to meal plan compliance: _____

Alcohol and Drug Use History Table

Drug of Choice	**Age of First Use**	**Use Frequency**	**Use Amount**	**Date of Last Use**	**How are you addressing the chemical use?** (Urine drug screens, Diary card, check ins, etc.)

History of treatment:

Inpatient or outpatient	**DOS** (Dates of Service)	**Facility/Service**	**Outcome** 1. Left AMA 2. Completed Successfully 3. Other-specify	**Duration of Improvement after treatment**	**Chemical use in treatment** (If yes- what chemical(s)?)

Support System (who the member lives with): _____

Other current level of care involvement/services: _____

Motivation for treatment: Self-motivated ☐ Seeking help ☐ Poorly motivated ☐

Participation in treatment plan: Cooperative/Active ☐ Uncooperative/Passive ☐

If uncooperative/passive, explain: _____

_____

On task with treatment assignments: Yes ☐ No ☐

If no, explain: _____

_____

_____

Progress made with treatment:
Satisfactory ☐ Satisfactory with concerns ☐ Unsatisfactory ☐

Explanation: _____

Discharge Plan/Recommendations: _____

_____

Projected Discharge Date: _____ **Actual Discharge Date:** _____

Follow up Appointments: _____

_____

Other Comments: _____

_____

_____

Submitted by: _____