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Substance Related 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: ____

Case Reference: ______________________ **Admit Date:** ______________________

Facility Contact: ______________________ **Direct Phone #**: ______________________

Treatment Setting:
Outpatient ☐ Residential ☐ Inpatient Treatment ☐ Inpatient Detox ☐ Extended Residential ☐

Axis I: ____

____

Axis II: ____

____

Axis III: ____

____

Axis IV: ____

____

Axis V: ____

____

Current GAF: ______________________ **Highest GAF in last 12 months:** ______________________

Risk Assessment:
The patient was assessed for substance abuse/dependence with a problem.

Trauma/Abuse history ☐	**Inability to care for self** ☐	**Self Ideation** ☐
Eating disorder ☐	**Family history of mental health issues** ☐	**Self injurious** ☐
Homicidality ☐	**Family history of chemical health issues** ☐	**Other** ☐

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Alcohol and Drug Use History Table

Drug of Choice	Age of First Use	Use Frequency	Use Amount	Date of Last Use

Detox Protocol Used: ______________________________

Detox Start Date: ______________________ Detox Completed: ______________________

Withdrawal Symptoms: ______________________________

Vitals: ______________________________

Consequences Related to Chemical Use: ______________________________

Mood/Behavioral Symptoms: ______________________________

Dimension I: Detox/ Withdrawal Potential (Risk Factor): Choose 0-4 ______
Explanation: ______________________________

____

Dimension II: Physical Health Risks/Complications (Risk Factor): Choose 0-4 ______
Explanation: ______________________________

____

Dimension III: Emotional, Behavioral, Cognitive Conditions/Complications (Risk Factor): Choose 0-4 ______
Explanation: ______________________________

____

Dimension IV: Readiness to Change (Risk Factor): Choose 0-4 ______
Explanation: ______________________________

____

Dimension V: Relapse, Continued Use, or Continued Problem Potential (Risk Factor): Choose 0-4 ______
Explanation: ______________________________

____

Dimension VI: Recovery/Living Environment (Risk Factor): Choose 0-4 ______
Explanation: ______________________________

____

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Prior CD Treatment: Yes ☐ No ☐

If yes, fill in the following history of treatment:

Inpatient or outpatient	DOS (Dates of Service)	Facility/Service	Outcome 1. Left AMA 2. Completed Successfully 3. Other-specify 4. Used chemicals in treatment	Length of Sobriety

Support System/Living Situation: ____________________

Treatment Plan/Goals: ____________________

Current Medications:

Medication	Dosage	When taken

For continuing care/retrospective reviews:

Group participation: Yes ☐ No ☐

On task with treatment assignments: Yes ☐ No ☐

On task with treatment expectations: Yes ☐ No ☐

Weekly Rating:

Satisfactory ☐ Satisfactory with concerns ☐ Unsatisfactory ☐

Discharge Plan/Recommendations: ____________________

Follow up Appointments:

Type of Service	Provider Name	Provider Agency	Phone Number	Date	Time

Estimated length of stay: ____________ **Date of discharge:** ____________________

Other Comments: ____________________

Submitted by (Name and title): ____________________

Submitted date: ____________________