FirstChoice VIP CARE PLUS by Select Health of South Carolina

Behavioral Health Clinical Fax Form

When complete, please fax to **1-855-396-5730**.

Today's date: _____ **Date of admission or service start:** _____

Type of review	**Estimated length of stay**
☐ Precertification ☐ Continued stay ☐ Discharge	(days/units)
Type of admission	
☐ Intensive outpatient ☐ Mental health inpatient ☐ Partial hospitalization program ☐ Substance use detox in a hospital setting	
Admission status	**Readmission within 30 days**
☐ Voluntary ☐ Involuntary commitment	☐ Yes ☐ No

Member information	
Last, first, middle initial:	Date of birth:
Address:	Eligibility ID:
Emergency contact (other than primary caregiver):	Phone:
Parent, guardian, or legal representative:	Phone:

Provider information		
Facility or provider name:	NPI or tax ID:	Provider ID:
Address:	Attending M.D.:	
UM Review contact:	Phone:	
DSM-5 diagnoses (include mental health, substance use, and medical):		

Medications				
Medication name	**Dosage**	**Frequency**	**Date of last**	**Type of change**
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
Additional information:				

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Presenting problem or current clinical update (e.g., suicidal ideation, homicidal ideation, psychotic symptoms, mood/affect, sleep, appetite, withdrawal symptoms, chronic substance use)

Treatment history and current treatment participation
Previous mental health or substance use inpatient, rehab, detox:
Outpatient treatment history:
Is the member attending therapy and groups? ☐ Yes ☐ No Explain clinical treatment plan:
Family involvement and support system:
Substance use: ☐ Yes ☐ No If yes, for mental health services only, please explain how substance use is being treated.

Please complete below for current American Society of Addiction Medicine (ASAM) dimensions and/or submit with documentation for substance use detox.

Dimension rating (0 – 4) Current ASAM dimensions are required.	
Dimension 1: Acute intoxication and/or withdrawal potential	**Rating:**
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	**Rating:**
Vital signs:	
Is member under a health care provider's care? ☐ Yes ☐ No Current medical conditions:	
History of seizures? ☐ Yes ☐ No	

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Dimension rating (0 – 4) continued Current ASAM dimensions are required.	
Dimension 3: Emotional, behavioral, or cognitive conditions and complications	**Rating:**
Mental health diagnosis:	
Cognitive limits? ☐ Yes ☐ No	
Psych medications and dosages:	
Current risk factors (e.g., suicidal ideation, homicidal ideation, psychotic symptoms):	
Dimension 4: Readiness to change	**Rating:**
Awareness and 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	**Rating:**
Relapse prevention skills:	
Current assessed relapse risk level: ☐ High ☐ Moderate ☐ Low	
Longest period of sobriety:	
Dimension 6: Recovery and living environment	**Rating:**
Living situation:	
Sober support system:	
Attendance at support group:	
Issues that impede recovery:	

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

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