Adult Behavioral Health Residential Facility or HCTC Preadmission Review

Form 3.14.5

Please Print Clearly

Provider Information		
Provider:	Staff Completing Form:	Credentials:
Provider Phone:	Provider Fax:	Medical Health Plan:
PCP Name:	PCP Phone:	ALTCS: ☐ Yes ☐ No

Recipient Information		
Recipient's Name:	DOB:	Social Security Number:
Gender: ☐ Female ☐ Male	Ethnicity:	Language:
U.S. Citizen: ☐ Yes ☐ No	Priority Population: ☐ Yes ☐ No	T19/21 Status:
COT Type:	Expiration Date:	ACT: ☐ Yes ☐ No

Address:		Currently Homeless: ☐ Yes ☐ No	
City:	State:	Zip code:	Phone:
Current Location:		Current Income:	
Guardian's Name:	Guardian's Phone:	Guardian's Email:	
Payee's Name:	Payee's Phone:	Payee's Email:	
DDD System Case Manager's Name:	DDD System Case Manager's Phone:	DDD System Case Manager's Email:	

Current Diagnosis		
	Code	**Description**
Axis I:		
Axis II:		
Axis III:		
Axis IV:		☐ Primary Support ☐ Social Environment ☐ Educational ☐ Occupational ☐ Housing ☐ Economic ☐ Access to Health Care ☐ Legal ☐ Other Psychosocial/Environmental
Axis V: (current):		

Mental Status

Current Risk			
	Ideation	Plan	Means
Danger to Self			
Danger to Others			

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Substance Abuse				
Substance	Age of 1st Use	Date of Last Use	Frequency of Use	Comments

Previous Substance Abuse Treatment			
Facility Name	Type/Level of Care	Admission/Discharge Dates	Reason for Discharge
Date ASAM Completed:		Level:	

Psychiatric/Substance Abuse Hospitalizations (including subacute) in the past year (Attach additional sheets if needed)			
Facility Name	Admission Date	Discharge Date	Reason for Admission
Current Medical Conditions, include diagnosis, plan for ongoing monitoring, care, and supplies:			

Current Medications - Psychiatric and Medical (Attach additional sheets if needed)					
Medication	Dose	Schedule	Medication	Dose	Schedule

Legal History (Attach additional sheets if needed)			
Offense	Type of Offense	Probation/Detention Status	Dates
	☐ Felony ☐ Misdemeanor		
	☐ Felony ☐ Misdemeanor		
	☐ Felony ☐ Misdemeanor		
Currently on Probation: ☐ Yes ☐ No		Currently on Parole/Community Supervision: ☐ Yes ☐ No	
Convicted Sex Offender: ☐ Yes ☐ No	If yes, Level:	☐ Adult ☐ Child	

Recipient Name:	SSN:

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If yes, Requires Flyers? ☐ Yes ☐ No	If yes, Requires Registration? ☐ Yes ☐ No
Precipitating Event (initial onset of symptoms, behaviors and surrounding events)	
Proximal Event (why now as opposed to any other time)	
Functional Strengths (Attach additional sheets if needed)	
Functional Barriers (Attach additional sheets if needed)	
Environmental Stressors (Attach additional sheets if needed)	
Support Systems	
Targeted Treatment Goals (goals that can not be addressed in alternative environment)	
Discharge and Aftercare Plan	
Comments	

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