HIGHMARK WHOLECARE

Behavioral Health Authorization Request Form

Please Fax Completed Form To: 1-888-245-2027
Behavioral Health Department: 1-800-685-5209

Type of request: □ **Admission** □ **Continued Stay/Authorization #**_____

Member Name:	**Member ID Number:**
Member Phone Number:	**Member Date of Birth:**
***Requesting* Facility Name:**	**Person Completing Form/Phone Number:**
***Admitting* Facility:**	**Admitting Facility Contact/ Phone Number:**
Date/Time of Admission:	**Treating Physician:**
Commitment Status/Pending Hearings: *(if applicable)*:	**Member's Preferred Language:**
Substance Use History: □ **No** □ **Yes *(Please Specify Substance of Choice, Amount of Use)*** **Details:**	
Drug screen results and alcohol level on admit:	
Tobacco Use: □ **No** □ **Yes**	
Legal Issues: □ **No** □ **Yes *(please explain):***	

List All Diagnoses *(Including Medical Comorbids):*

REV: 12/2020

Please call the Behavioral Health Team with Any Questions at 1-800-685-5209

Member Name:

Current Symptoms *(check all that apply)*

□ Suicidal Ideation

Details:

□ Homicidal Ideation

Details:

□ Psychosis
- **□ Hallucinations**
  Details:
- **□ Delusions/Paranoia**
  Details:

□ Self Injurious Behaviors **Details:**	**□ Aggression/Assaultive Behaviors** **Details:**

Mood:	**Affect:**	**ADLS:**	**Appearance:**
□ Depressed	**□ Euthymic**	**□ WNL**	**□ Good**
□ Anxious	**□ Dysphoric**	**□ Good**	**□ Fair**
□ Labile	**□ Congruent**	**□ Fair**	**□ Poor**
□ Elated	**□ Labile**	**□ Poor**	**□ Disheveled/Unkempt**
□ Irritable	**□ Flat**	**□ Independent**	**□ Malodorous**
□ Other:	**□ Other:**	**□ Other:**	**□ Other:**

Appetite:	**Eye Contact:**	**Insight:**	**Judgement:**
□ Good	**□ Good**	**□ Good**	**□ Good**
□ Fair	**□ Fair**	**□ Fair**	**□ Fair**
□ Poor	**□ Poor**	**□ Poor**	**□ Poor**

Sleep:	**Cognition:**	**Speech:**	
□ Good	**□ Attentive**	**□ WNL**	**□ Pressured**
□ Fair	**□ Unable to Focus**	**□ Rapid**	**□ Latency**
□ Poor	**□ Poor Concentration**	**□ Loud**	**□ Impoverished**

Additional Treatment Plan and Orders:		**Thought Process/Content:**	
□ Suicide Precautions	**□ 1:1 Observations**	**□ WNL**	**□ Tangential**
□ Seclusion	**□ Restraints**	**□ Goal Directed**	**□ Preoccupied**
□ Forced Meds		**□ Loose Associations**	**□ Bizarre**
□ Other:		**□ Flight of Ideas**	**□ Perseverative**
		□ Thought Blocking	**□ Circumstantial**

Additional Clinical Information:

Member Name:

MEDICATION				**CHANGES SINCE LAST REVIEW	
Medication	**Dosage**	**Route**	**Frequency**	****Medication Changes Since Last Review** *(N/A on Admits)*	****Date of Change** *(N/A on Admits)*

Have PRN's Been Given Since Last Review □ **No** □ **Yes** ***(Please Specify Below)***

Medication	Dosage	Route	Frequency and Dates Given

Support System

Does Member Have Family/Informal Supports: □ **No** □ **Yes** ***(Please Specify Below)***

List:

Is There Existing Outpatient Care/Case Manager/ACT Team:
□ **No** □ **Yes** ***(Please Specify Below)***

Provider Name	Type of Service	Contact Name	Phone Number	Notified
				□ **No** □ **Yes**
				□ **No** □ **Yes**
				□ **No** □ **Yes**

Current living situation:

Is Member Able to Return To This Housing Following Discharge? □ **No** □ **Yes**

Barriers to Treatment:

Transportation to Appointments:	**Pharmacy Name/Phone Number:**

Discharge and Aftercare Plan

(include provider member will be seeing upon discharge from this admission)