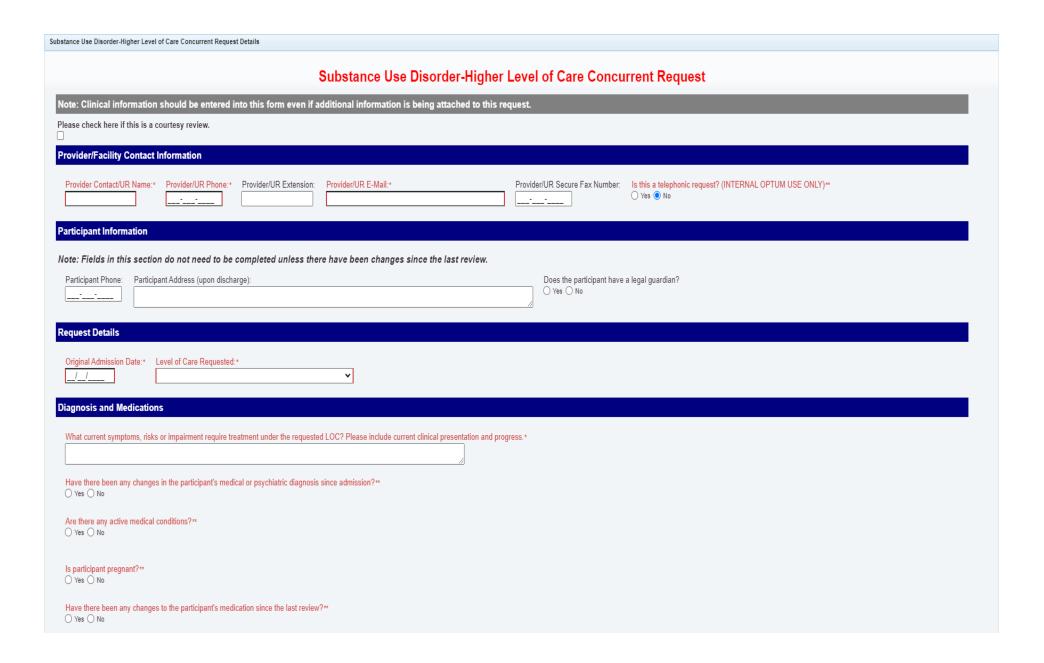
## Substance Use Disorder – Higher Level of Care Initial Request



Are there any barriers/issues related to the medication regimen?**  O Yes O No
Precipitant for Admission
What was the primary precipitant/circumstances that led to this admission?*  Provide additional detail about the specific event leading to this treatment episode:*
Provide additional detail about the specific event reading to this treatment episode.*
What current symptoms, risks or impairment require treatment under the requested LOC? Please include current clinical presentation and progress.*
Substance Use Information
Current Vitals:*
Current vitals within normal limits?**  O Yes O No O Not Applicable
Was a urine drug screen (UDS) completed?**  Yes No
Blood Alcohol Level:
Any history of medically-treated withdrawal seizures or DT's?**  O Yes O No
Is participant currently receiving Medication Assisted Treatment (e.g. Vivitrol, Naltrexone, Methadone)?**  O Yes O No
Opioid Use Disorder Diagnosis?**  O Yes O No
Has MAT been tried in the past?**  Yes No
Primary Care Physician (include name and contact information):

Outpatient Mental Health Provider (include name and contact information):	
Substances	
Primary Substance	
Primary Substance of Use*  Route of Administration:* Frequency of Use:* Date of Last Use:* Age at First Use:*  V V / / /	Additional Substances?  ✓ Yes ○ No
ASAM Dimension Risk Ratings	
Dimension 1-Acute Intoxication and/or Withdrawal	
Dimension 1 Risk Rating:**  ○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger	
Describe Dimension 1 (include CIWA or COWS, if applicable):*	
Dimension 2-Biomedical Conditions and Complications	
Dimension 2 Risk Rating:**  ○ 0-No Risk ○ 1-Mild ○ 2-Moderate ○ 3-Serious ○ 4-Imminent Danger	
Describe Dimension 2:*	
Dimension 3-Emotional, Behavioral or Cognitive Conditions and Complications	
Dimension 3 Risk Rating:**  O 0-No Risk O 1-Mild O 2-Moderate O 3-Serious O 4-Imminent Danger	
Describe Dimension 3:*	
Dimension 4-Readiness to Change	
Dimension 4 Risk Rating:**  O 0-No Risk O 1-Mild O 2-Moderate O 3-Serious O 4-Imminent Danger	
Describe Dimension 4:*	

Dimension 5-Relapse, Continued Use or Continued Problem Potential
Dimension 5 Risk Rating:**  O -No Risk O 1-Mild O 2-Moderate O 3-Serious O 4-Imminent Danger
Describe Dimension 5:*
Dimension 6-Recovery/Living Environment Risk
Dimension 6 Risk Rating:**  O -No Risk O 1-Mild O 2-Moderate O 3-Serious O 4-Imminent Danger
Describe Dimension 6:*
Recovery/Discharge Plan
What specific actions or treatment are planned to address the acute symptoms or behaviors?*
Facility planned discharge level of care:*  V
Estimated Length of Stay (ELOS)/number of days:*
Discharge Plan:*
Barriers to discharge and plans to address them to promote sustained recovery:*
Please provide any relevant information not otherwise discussed that is important for the review of this case?

Confirmation & Attestation
Please note this authorization request is not a guarantee of payment, coverage is still subject to applicable State of Maryland benefits.  I attest all of the information provided is accurate and reflected in the participant's medical record.*
important:
1) When this form is saved a pop-up box will appear regarding an additional form being recommended.
2) Click Continue to move to the next form, DO NOT click Decline.
3) Do NOT click Cancel or the "X" on the top right of the screen before completing the Data Capture form.
4) After completing the Data Capture form, click Save and you will be returned to the authorization screen.

Data Capture Required:

O Yes