**\*SUBMIT DEMOGRAPHIC FORM WITH INITIAL REQUESTS**

**\* Indicates a required field**

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| Please check: [ ]  Initial Request [ ]  Continuing Request (Client seen by you within the last 6 months) |
| **Client Information**  |
| \*Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Gender: [ ]  M [ ]  F [ ]  O | Age: \_\_\_\_\_ | \*DOB: \_\_\_\_\_  | Client Ethnicity: \_\_\_\_\_\_\_\_\_ |
| \*Living Situation: [ ]  Homeless [ ]  Alone [ ]  ILF [ ]  B&C [ ]  SNF [ ]  Other, with whom? \_\_\_\_\_\_\_\_\_\_\_ | \*Medi-Cal #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| San Diego Regional Center Client:[ ]  Yes [ ]  No | Current Employment /School Status:[ ]  Employed [ ]  Student [ ]  Homemaker [ ]  Retired [ ]  Unemployed [ ]  Seeking Work [ ]  Not in Labor Force [ ]  Unknown [ ]  Other |
| Justice System Involvement: [ ]  N/A [ ]  Yes If Yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \*Current Referral by Child and Family Well-Being (CFWB) Department: [ ]  Yes [ ]  No \*If Yes, PSW name and number: \_\_\_\_\_\_\_\_\_\_\_  | If History of CWS/CFWB, when and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Diagnosis and Other Clinical Considerations** |
| \*Primary DSM/ICD Diagnosis with Specifier: \_\_\_\_\_\_\_\_\_\_ | \*ICD Code: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Diagnoses (Mental & Physical Health): \_\_\_\_\_\_\_\_\_\_\_ |
| **Presenting Mental Health Problems and Symptoms** |
| \*Current Symptoms (List the frequency and duration) that result in impairment: \_\_\_\_\_\_\_\_\_\_\_ |
| \*Problem List: [ ]  Reviewed/updated  [ ]  No changes | Date: \_\_\_\_\_\_\_\_\_\_\_\_ |
| **Significant Impairment** |
| **\*Distress, Disability, or Dysfunction in:**  | **Yes** | **No** |
| Social/Relational |[ ] [ ]
| Occupational/Academic |[ ] [ ]
| Other Important Activities |[ ]  [ ]  |
| Reasonable Probability of Signification Deterioration in an Important Area of Life Functioning |[ ] [ ]
| Reasonable Probability of Not Progressing Developmentally as Appropriate (If Under 21) |[ ] [ ]
| **\*Explain Significant Impairment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **\*History of Trauma and/or Abuse:** [ ]  Yes [ ]  No\*If Yes, explain: \_\_\_\_\_\_\_\_\_\_ |
| **\*Substance Use:** [ ]  No [ ]  History [ ]  Current \*Drug(s) of choice: \_\_\_\_\_\_\_\_\_\_ |
| \*If current substance use, describe impact on functioning: \_\_\_\_\_\_\_\_ |
| **\*Current Risk Assessment:** | Suicidal: [ ]  No [ ]  Ideation [ ]  Plan [ ]  Intent [ ]  History of harming self |
|  | Homicidal: [ ]  No [ ]  Ideation [ ]  Plan [ ]  Intent [ ]  History of harming others |
| **Medications (Psychiatric, Medical & OTC)**  |
| Name of Medication: | Medication Dosage: | Name of Medication: | Medication Dosage: |
| \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| [ ]  No Medications |
| **Interventions** |
| List Interventions (CBT, DBT, etc.): \_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
|  |
| [ ]  Group Therapy, Number of participants: \_\_\_\_\_ Group Topic: \_\_\_\_\_\_\_\_\_\_\_ |
| **Provider Requested Authorization Units****Important: You must be a current contracted provider through Optum, Public Sector San Diego****to be able to obtain authorization for services and payment.** |
| Interpreter needed for these sessions: [ ]  No [ ]  Yes, Language: \_\_\_\_\_\_\_\_\_\_ |
| **If Initial Request, First Date of Assessment:** \_\_\_\_\_\_\_\_\_\_\_ |
| **Treatment** | **\*Begin Date of Sessions** | **\*Number of Sessions** | **\*Frequency Number of Sessions per Week/Month/Year** | **Optum Clinician Signature:**(For Optum Care Advocate Signature – Internal Use Only) |
| Psychotherapy (max 1 per day, max 12 total) | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |  |
| Group Psychotherapy (max 12, specify length of session) | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |  |
| Other: \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |  |
| Team Conference (99366 or 99368)(max 1 unit per day) | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_ |  |
| Targeted Case Management(T1017, 1 unit = 15 minutes) | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |  |
| Targeted Case Management will focus on:[ ]  Medical, Explain: \_\_\_\_\_\_\_\_\_\_[ ]  Social, Explain: \_\_\_\_\_\_\_\_\_\_[ ]  Educational, Explain: \_\_\_\_\_\_\_\_\_\_[ ]  Other Services, Explain: \_\_\_\_\_\_\_\_\_\_ |  |
| **Provider Information** |
| \*Name/Licensure: \_\_\_\_\_\_\_\_\_\_ |
| \*Phone: \_\_\_\_\_\_\_\_\_\_ | Fax: \_\_\_\_\_\_\_\_\_\_ |
| \*Provider Signature:  | \*Date: \_\_\_\_\_\_\_\_\_\_ |
| If Group Practice, Name of Group: \_\_\_\_\_\_\_\_\_\_ |
| [ ]  Check here to waive verbal notification of authorization determination for initial requests. Written notification will be sent for all requests.  |