This form should be used by FFS provider to request outpatient treatment. Revised 8.26.16	COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN **OUTPATIENT AUTHORIZATION REQUEST** Please check: ☐ Initial Request ☒ Continuing Request **PLEASE SUBMIT DEMOGRAPHIC FORM W/INITIALS**	To request authorizations, fax or mail to: Optum Public Sector Fax: (866) 220-4495, PO Box 601340 San Diego, CA 92160-1340 Phone: (800) 798-2254, option #5

CONFIDENTIAL **Client Information** ***CONFIDENTIAL***

Client Last Name: First: Middle: doe, john, middle

Gender: ☒M ☐F ☐O

Birth Date: 12/ 12 / 19xx

Age: 34

Marital Status: ☐S ☒M ☐D ☐Sep ☐Wid

Client Address (include zip code): ######### Sunny Sun Drive, San Diego, CA #####

Living Situation: ☐Homeless ☐Alone ☐ILF ☐B&C ☐SNF ☒Other, With whom? Apartment- wife & 2 kids

Primary Phone: ### ### ####

Medi-Cal CIN #: ########A

Highest Education Level: High School

Current Employment Status: Seeking Employment

Client Ethnicity: Pakistani

Current Managed Care Plan: One of the 5 Medi-Cal MCPs

If Child, current IEP: ☐Yes ☐No
School District: N/A

Justice System Involvement: ☐N/A ☒Yes
If Yes, explain: Probation-drug possession

San Diego Regional Center Client: ☐Yes ☒No

If Yes, contact name and number: N/A

Referred by Child Welfare Services: ☐Yes ☒No

If Yes, PSW name and number: N/A

If Hx of CWS, when and why? 1992-1993 physical abuse by dad

DSM IV/ICD 10 Diagnosis and Other Clinical or Medical Considerations

Primary Diagnosis: Major Depressive Disorder, Recurrent w/ Psychosis

ICD 10 Code: F33.3

Other Diagnoses (Mental & Physical Health): Cannabis Dependence Disorder, Diabetes type 2

Presenting Mental Health Problem, Symptoms, Functional Impairment

How is the client significantly impaired in an important area of life functioning as a result of their current symptoms or diagnosis? If client is a child, how is their development at risk of not progressing appropriately due to their symptoms or diagnosis? Daily depressed mood, 15 pound weight loss in the last 3 months, lack of appetite, diminished interest in most activities, hypersomnia-almost 12 hours a day, fatigue, difficulty concentrating, worthlessness, SI no specific plan, delusions-thinks wife is cheating and the neighbors are plotting against him, isolates, uses cannabis to detach and cope with PI, difficulty getting out of house to apply to jobs and has had difficulty connecting when goes to job interviews, stress in marriage due to PI and delusions, wife threatening to leave him and take their kids, police have been called due to delusions about neighbors

Hx of Trauma and/or Abuse? ☒Yes ☐No

If Yes, explain: Hx physical abuse from father

Substance Use: ☐N/A ☐Hx ☒Current

Drug(s) of choice: cannabis

Describe current substance use impact on functioning: Use of cannabis is effecting motivation for job search and increasing PI and delusions

Current Risk Assessment:						
	Suicidal -	☐N/A	☒Ideation	☐Plan	☐Intent	☐History of harming self
	Homicidal -	☒N/A	☐Ideation	☐Plan	☐Intent	☐History of harming self

Client Strengths (i.e., motivated, employed, strong social supports): seeking help, insightful, has family that loves him, intelligent

Medications (Psychiatric, Medical, & OTC medications)

Name of Medication w/ Dosage:

zoloft 200mg		
seroquel 300 mg hs		
metformin 850 mg bid		

Treatment

Proposed Interventions (CBT, DBT, behavioral, strengths-based, groups, etc.): CBT for addressing depression, grounds exercises, reality orientation, behavioral shaping, focusing on strengths, MI for increasing motivation for reducing cannibis and increasing job search, groups

If Group Therapy, # Participants: 8 Group Topic/Focus: Coping with depression

Treatment plan with measureable/observable goals addressing diagnosis, functional impairments, and risk (include frequencies and duration of treatment goals and separate Individual and Group if facilitating both): Individual goals: reduce days in bed from 7 days a week to 6 days a week, reduce calls to police from 1x month to 1x every 6 mo, increase connection with wife by teaching client 3 ways to ask for help when he is feeling depressed

Group goals: Increase knowledge of depression from ability to list 3 symptoms to able to list 6 symptoms, learn 3 skills in a group setting on how to cope with depression in large groups or while doing a task, learn & utilize deep breathing skills to increase coping with stressors from 0x/week to 2x/week, learn and utilize "I statements" to increase positive expression of feelings/emotions from 0x/week to 2x/week

Current treatment provided by others and/or Hx (i.e., Psychiatrist, PCP, NP, CM, TBS, Substance Use Tx, Groups, Peer Support): Meds with Dr MD Psychiatrist, CM with County CM

How have you coordinated with these providers? If not, please explain: Call monthly to CM to check progress, called MD 1 month ago to request possible increase in antipsychotic due to increase in PI and delusions

Progress: ☐N/A (Initial Request) ☐Near completion ☐Improving ☒Stabilizing ☐Regressed due to new stressor ☐Little no/progress

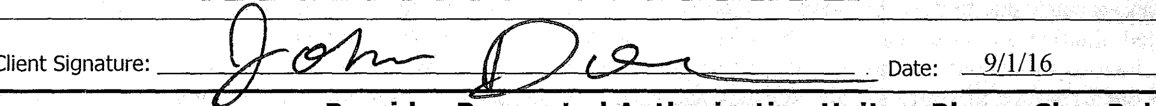
Expected length of treatment: 6mo to 1 year

If Initial Request, date of 1st Appointment/Assessment with you: N/A

Referrals made to other community supports and/or aftercare plans for client's recovery: Local clubhouse, job search training program, SMART recovery

Client Signature

******I, (print name)* JOHN DOE *participated in the development of this plan and received a copy.*

Client Signature:  Date: 9/1/16

Provider Requested Authorization Units – Please Sign Below

On Begin Date of Sessions, Client is: ☒**Adult** ☐**Child**

Interpreter needed for these sessions: ☐**No** ☒**Yes, Language:** Urdu

CPT Code Group	Treatment	Begin Date of Sessions	# of Sessions	Frequency # Sessions per Wk/Mo/Yr	For Optum Care Advocate Sign Approved Service
90834	Psychotherapy (max 12)	8/1/16	12	1x wk	
90853	Group Psychotherapy (max 12, specify length of session)	8/8/16	12	2x mo, 1 hr each	
99366/ 99367	CFT Meeting (CWS only)/ Team Conference	8/1/16	6	2x mo	
	Conference Purpose: Conference call with MD, CM, Clubhouse-staff plan how to support job search				
Z5820/ Z5821	Case Management				
	Case Management Purpose:				
Other					
Other					

Provider Information

Name/Licensure: Suzie Que Provider, LMFT ####

Phone: ### ### ####

If Initial Request, Date Called w/ Decision:

Provider Signature: Suzie. Que	Date: 9/1/16	Fax: ### ### ####	**If Modified or Denied, Date of NOA:**
If Group Practice, name of Group: n/a			

For Optum Care Advocate

If Request Modified or Denied, below sessions were authorized:

Authorized Treatment	Begin Date of Auth	# of Sessions	Frequency	Optum Signature