**SUBMIT DEMOGRAPHIC FORM WITH INITIAL REQUESTS**

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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 | | | | | | | | | | | |
| Current Referral by Child Welfare Services:  Yes  No  If Yes, PSW name and number: | | | | | | | If History of CWS, 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 Problem List reviewed/updated: | | | | | | | | | | | |
| **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:** | | | | | | | | | | | | | | | |
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| **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: | | | | | | | | | | | | | | | |
| **Medications (Psychiatric, Medical & OTC)** | | | | | | | | | | | | | | | |
| **Have you checked CURES:  Yes  No** | | | | | | | | | | | | | | | |
| Name of Medication: | | | Medication Dosage: | | | | | Name of Medication: | | | | | | Medication Dosage: | |
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| If no medications, explain plan for medications/or need for medication monitoring: | | | | | | | | | | | | | | | |
| **Provider Requested Authorization Units** | | | | | | | | | | | | | | | |
| Interpreter needed for these sessions:  No  Yes, Language: | | | | | | | | | | | | | | | |
| **If Initial Request, First Date of Assessment:**  90792  99202-99205 | | | | | | | | | | | | | | | |
| **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) | | | |
| Outpatient Office Visit DO/MD/PA/PNP only – E/M codes and therapy (max 26) |  | | | |  | | | |  | | |  | | | |
| DO/MD/PA/PNP only – Psychotherapy Add on code (max 26) |  | | | |  | | | |  | | |
| MD/DO Medical Team Conference (99367) |  | | | |  | | | |  | | |
| PNP/PA Medical Team Conference (99366 or 99368) |  | | | |  | | | |  | | |
| Other: |  | | | |  | | | |  | | |
| 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: | | | | | | |
| Provider Signature: Date: | | | | | | | | | Fax: | | | | | | |
| If Group Practice, Name of Group: | | | | | | | | | | | | | | | |