**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:**  |
|  |
| **History of Trauma and/or Abuse:** [ ]  Yes [ ]  NoIf 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: |