**\*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 |
| \*If Client under 21, 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 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 [ ]  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 & Frequency: | Name of Medication: | Medication Dosage & Frequency: |
| \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| \*If no medications, explain plan for medications/or need for medication monitoring: \_\_\_\_\_\_\_\_\_\_\_\_ |
| **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:** \_\_\_\_\_\_\_\_\_\_\_\_[ ]  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)(max 1 unit per day) | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_ | 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. |