**\*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. | | | | | | | | | | | | | | | |