**\*SUBMIT DEMOGRAPHIC FORM WITH INITIAL REQUESTS**

**\* Indicates a required field**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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. | | | | | | | | | | | | | | | | |