

This form should be used to request outpatient treatment. Revised 01.13.22	COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN OUTPATIENT AUTHORIZATION REQUEST Please check: <input type="checkbox"/> Initial Request <input type="checkbox"/> Continuing Request PLEASE SUBMIT DEMOGRAPHIC FORM W/ INITIAL REQUESTS	To request authorizations, fax or mail to: Optum Public Sector Fax: (866) 220-4495, PO Box 601340 San Diego, CA 92160-1340 Phone: (800)798-2254, option 3 then 4
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CONFIDENTIAL	Client Information	CONFIDENTIAL
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Client Last Name:	First:	Middle:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	Client Ethnicity:
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Age:	DOB:	Living Situation: <input type="checkbox"/> Homeless <input type="checkbox"/> Alone <input type="checkbox"/> ILF <input type="checkbox"/> B&C <input type="checkbox"/> SNF <input type="checkbox"/> Other, with whom?	Justice System Involvement: <input type="checkbox"/> N/A <input type="checkbox"/> Yes
00/00/0000		If Yes, explain:	

Medi-Cal CIN #:	Highest Education Level:	Current Employment Status:
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Current Health Plan:	If Child, current IEP: <input type="checkbox"/> Yes <input type="checkbox"/> No School District:	San Diego Regional Center Client: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Current Referral by Child Welfare Services: <input type="checkbox"/> Yes <input type="checkbox"/> No:	If Yes, PSW name and number:
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If Hx of CWS, when and why?

DSM IV/ICD 10 Diagnosis and Other Clinical or Medical Considerations

Primary Diagnosis Description:	ICD 10 Code:
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Other Diagnoses (Mental & Physical Health):

Presenting Mental Health Problem, Symptoms, Functional Impairment

Current Symptoms (List the frequency and duration):

How is the client significantly impaired in an important area of life functioning as a result of their symptoms or diagnosis? If client is a child, how is their development at risk of not progressing appropriately due to their symptoms or diagnosis:

Hx of Trauma and/or Abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, explain:
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Substance Use: <input type="checkbox"/> N/A <input type="checkbox"/> HX <input type="checkbox"/> Current	Drug(s) of choice:
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Describe current substance use impact on functioning:

Current Risk Assessment:	Suicidal - <input type="checkbox"/> N/A <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> History of harming self Homicidal - <input type="checkbox"/> N/A <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> History of harming others
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Client Strengths (i.e., motivated, employed, strong social supports):

Medications (Psychiatric, Medical, & OTC medications)

Name of Medication w/ Dosage or N/A:

