

BHS REVIEW FORM FOR INTENSIVE OUTPATIENT (D&A)- ADULT

Client: _____
SSN# _____
Treating Physician: _____
Facility: _____
Telephone Number: _____
IOP Start Date: _____

CIS# _____
D.O.B _____
Phone: _____
Clinician: _____
Fax Number: _____
Provider Number: _____

Referral source:

- Step-down from Residential Referral Source:
- Referred from FIR/Treatment Court IPP
- Transfer from other IOP
- Transfer from OP
- No Prior treatment

Name of Provider: _____
Name of Case Manager: _____
Name of Provider: _____
Name of Provider: _____

Justification for IOP (include level of assessment to determine client's ability to participate in the level of intensity):

IOP PCPC CRITERIA

DIMENSION I:

- Minimal to no risk of withdrawal as evidenced by:
 - CIWA Scale below 10 after 8 hours of use
 - BAL is 0.0 g/m% and no signs of withdrawal
 - Narcotics Withdrawal Scale (Grades 1-4)

Client experiencing protracted withdrawal symptoms (define):

For clients with minimal withdrawal symptoms defined above, the client has responded positively to emotional support and comfort as evidenced by: a) decrease in emotional symptoms by the end of the interview session (please define):

DIMENSION II: Bio-medical conditions

Define current medical status, history/current medical conditions, complications related to drug use:

Severity of Medical Problems: Low Average High

Will it interfere with treatment : Yes No If Yes, define:

How will the medical problems detract from recovery efforts:

How will the IOP provide medical monitoring/medical management for this client: Directly Concurrent arrangement

Clinician's Signature: _____

Date: _____

DIMENSION III: (Emotional/Behavioral): Describe current mental status including insight/judgment, mood/affect, thought content, orientation, past/present psychiatric symptoms/treatment, psychiatric medications, and pattern of behavior as it relates to substance use.

Appearance:

- | | |
|--|---|
| <input type="checkbox"/> Appropriately Dressed | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Inappropriately Dressed | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Poor Hygiene | <input type="checkbox"/> Lesions/Scars/Ulcers |
| <input type="checkbox"/> Disorganized/disheveled | <input type="checkbox"/> Other: |

Memory:

- Intact
- Poor Remote
- Poor Recent
- Impaired

Thought Process/Content:

- Hallucinations Type: Auditory Visual Other
- Delusions
- Suicidal/Homicidal w/plan
 - Suicidal/Homicidal without plan
- Loose Associations
- Flight of Ideas
- Hopeless/Helpless
- Normal

Insight/Judgment:

- Intact
- Poor abstract
- Impaired
- Lacks insight

Sensorium:

- Oriented x 3
- Oriented to person only
 - Oriented to place only
- Oriented to time only
- Other:

Speech:

- | | |
|---|--|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Pressured |
| <input type="checkbox"/> Slow | <input type="checkbox"/> Poverty of Speech |
| <input type="checkbox"/> Slurred | <input type="checkbox"/> Faulty grammar |
| <input type="checkbox"/> Disturbed articulation | |

Mood:

- Normal
- Depressed
- Bright
- Anxious

Affect:

- Normal
- Blunted
- Depressed
- Defensive
- Reactive
- Labile
- Inappropriate thought content
- Other

Behavior:

- | | | | |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Submissive | <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Poor Impulse Control | <input type="checkbox"/> Tremors | <input type="checkbox"/> Bizarre Gestures |
| <input type="checkbox"/> Agitated | <input type="checkbox"/> Psychomotor Agitation | <input type="checkbox"/> Aggressive | |

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____ (GAF Score)

Code: _____

Code: _____

Does the client's current mental status interfere with treatment: Yes No

If Yes, explain how the IOP will provide support:

DIMENSION IV: Treatment Resistance/Acceptance- Describe history of treatment, outcome of prior treatment episodes, motivation now for treatment, issues that may present as barriers to accessing treatment, special needs:

Is client able to recognize that he or she has a problem with substance use: Yes No

If No, explain evidence that supports client's inability to acknowledge presence of a problem:

History of AMA's Yes No

If yes, explain:

DIMENSION V: Relapse Potential

Describe periods of abstinence, results of UDS and date taken (excluding name of drugs found in drug test), individual's ability to understand his addiction and related consequences:

DIMENSION VI: Recovery Environment

Define the individual's housing status, support systems (or lack thereof), and any barriers that may present difficulty for the individual in accessing treatment or participating in treatment related to his environment:

IOP Services (Please check as many as apply):

- Individual Therapy
- Group Therapy
- Psycho-education Groups (Specify type: _____)
- Random Drug Screens (How often: _____)
- Psychiatric Evaluation (one per episode if medically necessary)
- Medication Checks
- Methadone Maintenance/LAAM

Signature of Assessor: _____

Date : _____