CLEAR FORM

REQUEST FOR EXTENDED SERVICE REVIEW (RES)
SUBMIT TO MENTAL HEALTH PLAN BEFORE 4th VISIT TO:
Authorization Services
Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
Phone (510) 567-8141 Fax (510) 567-8148

Client Name: _____
Client DOB: _____
Client CIN or SSN: _____
Provider Name: _____
Agency, if applicable: _____
Provider Phone: _____

General Instructions:

- When completing this form online, identifying information from the box above will automatically appear on all other pages.
- ***If client has a CIN (Client Info. Number), the CIN must be used per State regulations. (CIN is on Medi-Cal card & in AEVS)***
- Respond legibly to all questions; indicate "N/A" or "none" if the question is not relevant to this client.
- Incomplete or illegible forms will be returned to sender. *Tip: Online completion reduces returns!*
- Remember to submit all 5 pages of the RES – your signature and the client's signature are required on page 5.
- *Submit extra page, if needed, and check the following box to alert Authorization Services staff:* ☐

RELATED TO YOUR REIMBURSEMENT

- Date of first face-to-face contact with client: _____
- If you have multiple sites, at which site does this client receives services?

1. **CLIENT ASSESSMENT INFORMATION:**
   Current Presenting Problem as viewed by the client and significant support persons, when applicable.

2. **Current Clinical Risks:** Identify risk to client and/or others, including situational risks **AND** your management of those risks? (e.g., "DTS low risk; made safety plan, gave emergency contact & suicide hotline number.")

3. **Other Current Mental Health Providers:** (e.g., agency assistance, case manager, therapist, psychiatrist)

4. **Summary of Mental Health History** (e.g., danger to self/others, hospitalizations, other treatment)

5. **Other Relevant History**: (e.g., social, work, education, etc.)

Client Name: _____ Client CIN or SSN: _____
Provider Name: _____

6. **Client under age 18, complete developmental history** (pre/perinatal events, physical/intellectual/psychosocial/academic):
☐ N/A (client 18+) ☐ In chart ☐ In progress; estimate complete by:_____

☐ Unable to obtain info. due to:

PROVIDER TO COMPLETE

7. **Summary of Medical Conditions:** (**IF PROVIDING MEDICATION SUPPORT, COMPLETE BOX 7A. BELOW INSTEAD**)
Physical health conditions (as relevant, including those in remission):

Note: All allergies must be prominently noted on chart front or marked NKA

Current medications, as reported by client:
Psychiatric Rx (dose/freq., e.g., 20 mg 2x/day):

MD Name/Agency _____ Phone _____
Non-psychiatric Rx:

MD Name/Agency _____ Phone _____
Comments (e.g., herbal remedies, suspected compliance issues):

PHYSICIAN TO COMPLETE

7a. **Complete this box if Medication Support is provided** (instead of #7 above)
Active medical conditions:

Medication allergies/sensitivities: ***Note: All allergies must be prominently noted on chart front OR Noted NKA***

History of EPS? ☐ No ☐ Yes Current Assessment of EPS? ☐ No ☐ Yes

Past psychiatric medication: (Maximum dose, duration, when first prescribed, effectiveness, reason if discontinued)

Current Psychiatric medication (Dose, frequency, duration, target symptoms & response, side effects, and compliance):
(Note: Informed Consent must be in chart for all prescribed medication & when prescription is significantly changed.)

Non-psychiatric medication (dose, duration, target medical condition):

Comments:

Client Name: _____ Client CIN or SSN: _____
Provider Name: _____

8. **Summary of Substance Use History – Complete for all clients:**

	Current Use?	1st Use Date	Last Use Date
Alcohol	☐ No ☐ Yes	_____	_____
Tobacco	☐ No ☐ Yes	_____	_____
Caffeine	☐ No ☐ Yes	_____	_____
Prescriptions, not used as prescribed	☐ No ☐ Yes	_____	_____
Over-the-counter, not used per label	☐ No ☐ Yes	_____	_____
Illicit drugs:			
Indicate substance: _____:	☐ No ☐ Yes	_____	_____
_____:	☐ No ☐ Yes	_____	_____
_____:	☐ No ☐ Yes	_____	_____
_____:	☐ No ☐ Yes	_____	_____

Comments:

9. **Current Mental Status Exam** (WNL = Within normal limits):

Appearance/Behavior/Abnormal movements: ☐ WNL ☐ Other:_____
Speech: ☐ WNL ☐ Other:_____
Mood: ☐ WNL ☐ Depression ☐ Hypomania/mania ☐ Anxiety ☐ Anger ☐ Other:_____
Affect/Range: ☐ WNL ☐ Labile ☐ Restricted ☐ Inappropriate ☐ Other:_____
Thought Process: ☐ WNL ☐ Blocking ☐ Tangential ☐ Flight of Ideas ☐ Other:_____
Thought Content: ☐ WNL ***(If not WNL, a description below is required.)***
Hallucinations (**commands?**):_____
Delusions: _____
Suicidal ideations: _____
Homicidal ideations: _____
Other: _____
Orientation: ☐ WNL ☐ Other: _____
Concentration: ☐ WNL ☐ Other:_____
Memory: Immediate, Recent, & Remote ☐ WNL ☐ Other:_____
Intelligence: ☐ WNL ☐ Other:_____
Insight: ☐ WNL ☐ Other:_____
Judgment: ☐ WNL ☐ Other:_____
Impulse Control: ☐ WNL ☐ Other:_____
Attitude with interviewer & motivation for treatment: _____

If MSE is all WNL, please explain:

10. Does the client have any special needs that must be addressed? (cultural, communication, physical limitations)

Client Name: ___________________________________	Client CIN or SSN: ___________________________________
Provider Name: _________________________________	

11. **5 Axis Diagnosis:** (per DSM, current edition)

Axis I Primary: ____DSM code: _____________

Secondary: ____ DSM code: _____________

Tertiary: ____ DSM code: _____________

Axis II Primary: ____ DSM code: _____________

Secondary: ____DSM code: _____________

Axis III: ________________________________ per _____________________ (e.g., per client report, collateral w/ MD)

________________________________ per _____________________

________________________________ per _____________________

Axis IV Psychosocial & Environmental Concerns: ***(Check all that apply. If Severe is checked, this RES must address risk.)***

Key: Mild = functions normally with mild effort/support. Moderate = functions normally with moderate effort/support. Severe = functions normally only with substantial effort/support.

Problems with primary support group:	○ Mild	○ Moderate	○ Severe
Problems related to the social environment:	○ Mild	○ Moderate	○ Severe
Educational problems:	○ Mild	○ Moderate	○ Severe
Occupational problems:	○ Mild	○ Moderate	○ Severe
Housing problems:	○ Mild	○ Moderate	○ Severe
Economic problems:	○ Mild	○ Moderate	○ Severe
Problems with access to health care services:	○ Mild	○ Moderate	○ Severe
Problems with activities of daily living (ADL's):	○ Mild	○ Moderate	○ Severe
Problems re. interaction with legal system/crime:	○ Mild	○ Moderate	○ Severe
Other psychosocial/environmental problems:	○ Mild	○ Moderate	○ Severe

Axis V: ____ Current ____ Highest functioning in last 12 months

12. **Medical Necessity for Services** (see www.acbhcs.org/providers, Quality Assurance tab for definition)

Per clinician's current assessment, describe the medical necessity for mental health services: Indicate how the client's current symptoms cause specific problems in daily functioning that your services will address. Example: *"Current symptoms meet criteria for moderate major depressive disorder and lead to social avoidance, difficulty completing tasks at work, and parenting problems."*

13. **Tentative Discharge Plan** (termination/transition plan):

14. **[illegible]:**

Mp. If closing case, date of last session _____________ Referrals made:_______________________________________

Client Name: _____ Client CIN or SSN: _____
Provider Name: _____

CLIENT PLAN

Complete in collaboration with client whenever possible

1. Goals & Objectives

a. Client's Goals (stated in client's own words, when possible):

b. Client's current strengths/skills/resources/supports that can be utilized to reach listed Goals (e.g., client is motivated to reach goals, has family support, excellent knitting skills):

c. 6-Month Mental Health Objectives (observable or measurable) supporting improved mental health functioning *(e*.g., increase social activity by supporting client to attend knitting group 2x/month; improve concentration and decrease irritability by helping client practice stress reduction techniques):

2. Service Request for Authorization

Please use one line for each service.(Not required for HPAC)

CPT Service Code (per your rate sheet)	**Service Description** (per your rate sheet)	**Frequency of Service**	**Diagnosis Code(s) Addressed**
Example: x9502	Individual Therapy	1x/week	296.22

***CLIENT'S SIGNATURE:_____ Date_____**
Legal Representative's signature., if required:_____ Date_____
Specify Legal Rep.'s Relationship (e.g., parent, guardian, conservator): _____
If client/legal rep. verbally agreed with Client Plan but declined to sign, provide the Date: _____
If client/legal rep. disagrees with Plan, provide Reason/Date: _____

Client's signature required above AND client must be offered copy of Client Plan page unless clinician believes client's condition would suffer. If so, provide Reason/Date:_____

Provider/Clinician information is required on the line below.

_____

Clinician's printed name **Signature with discipline (e.g., MFT, LCSW, MD)** **Date**

If Clinician is not licensed, Licensed Supervisor's information is required on the line below:

_____

Lic. Supervisor's printed name **Signature with discipline (e.g., MFT, LCSW, MD)** **Date**

PRINT