



# Adult Level II, III and HCTC

## Preadmission Review

Form 3.14.5

**Please Print Clearly**

### Provider Information

Provider:	Staff Completing Form:	Credentials:
Provider Phone:	Provider Fax:	Medical Health Plan:
PCP Name:	PCP Phone:	ALTCS: <input type="checkbox"/> Yes <input type="checkbox"/> No

### Recipient Information

Recipient's Name:	DOB:	Social Security Number:
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Ethnicity:	Language:
U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	Priority Population: <input type="checkbox"/> Yes <input type="checkbox"/> No	T19/21 Status:
COT Type:	Expiration Date:	ACT: <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		Currently Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No
City:	State:	Zip code:
Current Location:		Current Income:
Guardian's Name:	Guardian's Phone:	Guardian's Email:
Payee's Name:	Payee's Phone:	Payee's Email:
DDD System Case Manager's Name:	DDD System Case Manager's Phone:	DDD System Case Manager's Email:

### Current Diagnosis

	Code	Description
Axis I:		
Axis II:		
Axis III:		
Axis IV:		<input type="checkbox"/> Primary Support <input type="checkbox"/> Social Environment <input type="checkbox"/> Educational <input type="checkbox"/> Occupational <input type="checkbox"/> Housing <input type="checkbox"/> Economic <input type="checkbox"/> Access to Health Care <input type="checkbox"/> Legal <input type="checkbox"/> Other Psychosocial/Environmental
Axis V: (current):		

### Mental Status

--

### Current Risk

	Ideation	Plan	Means
Danger to Self			
Danger to Others			



# Adult Level II, III and HCTC

## Preadmission Review

Form 3.14.5

### Substance Abuse

Substance	Age of 1 <sup>st</sup> Use	Date of Last Use	Frequency of Use	Comments

### Previous Substance Abuse Treatment

Facility Name	Type/Level of Care	Admission/Discharge Dates	Reason for Discharge

Date ASAM Completed:

Level:

### Psychiatric/Substance Abuse Hospitalizations (including subacute) in the past year (Attach additional sheets if needed)

Facility Name	Admission Date	Discharge Date	Reason for Admission

Current Medical Conditions, include diagnosis, plan for ongoing monitoring, care, and supplies:

### Current Medications - Psychiatric and Medical (Attach additional sheets if needed)

Medication	Dose	Schedule	Medication	Dose	Schedule

### Legal History (Attach additional sheets if needed)

Offense	Type of Offense	Probation/Detention Status	Dates
	<input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor		
	<input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor		
	<input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor		

Currently on Probation:  Yes    No

Currently on Parole/Community Supervision:  Yes    No

Convicted Sex Offender:  Yes    No

If yes, Level:

Adult    Child

If yes, Requires Flyers?  Yes    No

If yes, Requires Registration?  Yes    No

Recipient Name:	SSN:
-----------------	------



# Adult Level II, III and HCTC Preadmission Review

Form 3.14.5

**Precipitating Event** (initial onset of symptoms, behaviors and surrounding events)

**Proximal Event** (why now as opposed to any other time)

**Functional Strengths** (Attach additional sheets if needed)

**Functional Barriers** (Attach additional sheets if needed)

**Environmental Stressors** (Attach additional sheets if needed)

**Support Systems**

**Targeted Treatment Goals** (goals that can not be addressed in alternative environment)

**Discharge and Aftercare Plan**

**Comments**

Recipient Name:

SSN: