

**IOP CONTINUED STAY REVIEW AUTHORIZATION REQUEST FORM
IOP – CSR**

| | | | | | | | | | | | | | | | |
|--|--|--------------------------|--|--------------------------------|-----------------------|------------------------------------|--|-----------------------|--|--------------------------|--|--------------------|--|--|--|
| To be Completed by OBH | | | | | | Revised 2.16.16 | | | | | | | | | |
| Tracking # | | | | | | Date/Time of Receipt | | | | | | | | | |
| PROVIDER INFORMATION | | | | | | | | | | | | | | | |
| Provider Company Name | | | | | | | | | | | | | | | |
| Person Making Referral | | | | | | Credentials | | | | | | | | | |
| Provider Phone # | | | | | | Provider Fax # | | | | | | | | | |
| Date of Request | | | | Provider Email | | | | | | | | | | | |
| Provider Address | | | | | | | | | | | | | | | |
| CLIENT INFORMATION | | | | | | | | | | | | | | | |
| Recipient Name | | | | | | SS# | | | | | | | | | |
| Age | | DOB | | Ethnicity | | | | | | | | | | | |
| Gender | | Gender Expression | | | Marital Status | | | | | | | | | | |
| Parent/Guardian | | | | Phone # | | | | | | | | | | | |
| Address | | | | | | | | | | | | | | | |
| IOP CONTINUED STAY REVIEW REQUEST | | | | | | | | | | | | | | | |
| Admit Date | | | | | | Last Date Authorized by OBH | | | | | | | | | |
| Requested Start Date | | | | | | Requested End Date | | | | | | | | | |
| Are you requesting additional days, change in level of care, or recommending discharge? | | | | | | | | | | | | | | | |
| Additional Days | | <input type="checkbox"/> | | Change in Level of Care | | <input type="checkbox"/> | | Discharge(D/C) | | <input type="checkbox"/> | | Date of D/C | | | |
| Sessions per week in your IOP Program | | | | | | | | | | | | | | | |
| Current Diagnosis | | | | | | | | | | | | | | | |
| ICD10 Code | | | | | | | | | | | | | | | |
| Medications | | | | | | | | | | | | | | | |
| Changes to Current Medications | | | | | | | | | | | | | | | |
| Most recent UDS/BAL results | | | | | | | | | | | | | | | |
| REASON FOR EXTENDED AUTHORIZATION | | | | | | | | | | | | | | | |
| Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following: (check all that apply) | | | | | | | | | | | | | | | |
| <input type="checkbox"/> The persistence of problems that caused the need for IOP admission to a degree that continues to meet IOP criteria | | | | | | | | | | | | | | | |
| <input type="checkbox"/> The emergence of additional problems that meet the IOP admission criteria | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Disposition planning and/or attempts at therapeutic reentry into a less intensive level of care have resulted in, or would result in exacerbation of the substance related disorder to the degree that would necessitate continued intensive outpatient treatment. | | | | | | | | | | | | | | | |
| OR Continued stay needed due to: | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Court order or Judicial Commitment | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Probation or Parole | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Employment Related | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other - explain | | | | | | | | | | | | | | | |
| Detail the discharge plan as well as the anticipated day of discharge: | | | | | | | | | | | | | | | |
| Comment | | | | | | | | | | | | | | | |