CONNECTICUT
Behavioral Health Partnership

AIS WEB REGISTRATION FIELDS - OUTPATIENT & HOME BASED LEVELS OF CARE

1. **Registering for a 90801 Initial Evaluation Only**? ☐ YES ☐ NO

2. **Is this a new admission to outpatient services within your agency/practice?** ☐ YES ☐ NO

3. **Is member being discharged from a higher level of care within your agency/practice?** ☐ YES ☐ NO ***Note: (If n/a, select no)***

4. **RACE *(optional)*:** ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific ☐ White

5. **ETHNICITY: Hispanic/Latino Origin *(optional)*:** ☐ YES ☐ NO

6. **REFERRAL SOURCE:** ☐ Self/Family Member ☐ PCP/Medical Provider ☐ Step Down Intermediate LOC ☐ Step Down Inpatient LOC ☐ Other BH Provider ☐ School ☐ Comm. Collaborative ☐ CT BHP ASO ☐ DCF ☐ DMR ☐ DMHAS ☐ Hospital Emergency Dept ☐ Managed Service System ☐ Court-ordered ☐ Other Legal ☐ Other

7. **FIRST PHONE OR WALK IN CONTACT W/ MEMBER OR PARENT/GUARDIAN**: Date_____

8. **FIRST CONTACT WAS:** ☐ Walk-in ☐ Telephone

9. **REFERRAL TYPE:** ☐ Routine ☐ Urgent ☐ Emergent
   a. **If Routine or Urgent:** What was the 1st appt. that was offered to the member: _____
      What was the date of the 1st appt. that was accepted by the member? _____
      If applicable, # of no-shows/cancellations prior to first appt? **(Indicate #)** _____
      Date of first face-to-face Clinical Evaluation: _____
   b. **If Emergent :** Date and Time Presented at the Clinic: ____/_____/_____ DATE _____ AM / PM
      Date and Time of Clinical Evaluation: ____/_____/_____ DATE _____ AM / PM

10. **AXIS I – V (AXIS IDSM IV Diagnosis Code**) Axis I Diagnosis Date: ____/_____/_____
    AXIS I & II: AXIS I _____ (circle one: Primary, Secondary, Rule Out)
    AXIS I _____ (circle one: Primary, Secondary, Rule Out)
    AXIS II (if deferred, pls indicate)_____ (circle one: Primary, Secondary, Rule Out)
    AXIS II _____ (circle one: Primary, Secondary, Rule Out)
    a. **AXIS III**: ☐ None ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Cardiac Problem ☐ Chronic Pain ☐ Cystic Fibrosis ☐ Eating Disorder ☐ HIV ☐ Hearing Impairment ☐ Hepatitis ☐ Lupus ☐ Mobility impairment ☐ Neurological disorder ☐ Obesity ☐ Pregnancy ☐ Post-partum ☐ Sickle Cell ☐ Traumatic Brain Injury ☐ Type I Diabetes ☐ Type II Diabetes ☐ Visual impairment ☐ Other Axis III _____
    b. **AXIS IV**: _____
    c. AXIS V *(Indicate GAF Score 1-100)* _____

11. **If member had previous behavioral hlth treatment w/i the past 6 mos. Select all that apply:** ☐ N/A ☐ Mntl Hlth ☐ Sub Abuse

12. **Are there family members or significant others involved in the members treatment and recovery?** ☐ YES ☐ NO ☐ N/A
    a. **If yes**, are any of the family members/significant others receiving their own MH or SA treatment? ☐ YES ☐ NO

13. Have you obtained consent to contact:
    a. School ☐ YES ☐ NO ☐ DENIED
    b. Medical Provider ☐ YES ☐ NO ☐ DENIED
    c. Previous behavioral health treatment provider ☐ YES ☐ NO ☐ DENIED ☐ N/A
    d. BH treatment provider for family member/significant other ☐ YES ☐ NO ☐ DENIED ☐ N/A

14. **Who is the lead case management provider?** ☐ None ☐ DCF Case Worker ☐ DCF Enhance CC
    ☐ CC (System of Care Collaborative) ☐ DMHAS Case Manager

15. **Is the member currently taking psychiatric medications?** ☐ YES ☐ NO

16. **Is a psychiatric medication evaluation or medication management visit indicated?** ☐ YES ☐ NO

17. **Does member have co-occurring mental health and substance use conditions?** ☐ YES ☐ NO ☐ Not Assessed

18. Is the member involved with the legal system? Please select all that apply

    a. ☐ Juvenile Justice ☐ Probation ☐ Parole ☐ Other Court ☐ N/A

19. **Have you provided information regarding peer support or self-help options?** ☐ YES ☐ NO

20. **Effective date/Start date of authorization?** (EX: 09/01/06): _____

FEDERAL REPORTING REQUIREMENTS *ONLY* FOR MEMBERS 0-17 YEARS OF AGE

21. **SED (Seriously/Severely Emotionally Disturbed):** ☐ YES ☐ NO ☐ UNKNOWN

22. **Co-Occuring Disorder**: ☐ YES ☐ NO ☐ UNKNOWN

23. **Living Situation:** ☐ Independent Living w/Supports ☐ Crisis Stabilization Residential
    ☐ Foster Care (Therapeutic or Professional) ☐ Foster Care (Standard) ☐ Group Home ☐ Homeless
    ☐ Jail/Correctional Facility ☐ Private Residence ☐ Psychiatric Residential Treatment Facility
    ☐ Residential Treatment Center ☐ Safe Home ☐ Shelter

24. **Within the past 12 mos. has the child/youth been:** Arrested? ☐ YES ☐ NO ☐ UNKNOWN
    a. Suspended/Expelled? ☐ YES ☐ NO ☐ UNKNOWN

AIS WEB REGISTRATION FIELDS - METHADONE MAINTENANCE

(CORE OTPT QUESTIONS (Pg 1-2) plus THE FOLLOWING)

1. Is the member currently maintained on Methadone? ☐ YES ☐ NO
   a. If yes, how long has the member received Methadone services?
      ☐ 6 mos or less ☐ 7 mos – 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs >
   b. If no, what has been the duration of the member's opioid use?
      ☐ Less than 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs or >

2. What other services are included in the treatment plan?
   a. ☐ OP Therapy ☐ Comm. Supp. (NA/AA) ☐ IOP/PHP ☐ Other Behavioral Health Services ☐ PCP/MD Follow-up

3. What is the ultimate treatment goal? ☐ Methadone Maintenance ☐ Abstinence

AIS WEB REGISTRATION FIELDS - AMBULATORY DETOX

(CORE OTPT QUESTIONS (Pg 1-2) plus THE FOLLOWING)

1. From what substance is the member in need of detoxification? (**select all that apply**) ☐ Alcohol ☐ Opiates ☐ Benzodiazepines

2. Has the member had a previous detox in any setting in the past year? ☐ YES ☐ NO
   If yes, number of detoxes in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4+

3. What is the identified discharge plan? (**select all that apply**) ☐ OP Therapy ☐ Comm. Supp. (NA/AA) ☐ IOP/PHP
   ☐ Other Behavioral Health Services ☐ Methadone Services ☐ PCP/MD Follow-up

AIS WEB REGISTRATION FIELDS - PSYCHOLOGICAL TESTING:

(CORE OTPT QUESTIONS (Pg 1-2) plus THE FOLLOWING)

1. What is the referral question?

2. What is the patient's history including summary of psychosocial/medical info; treatment history; and type, duration and frequency of current services?

3. What were the results of previous testing including dates and findings?

4. What is the differential diagnostic question that the testing will answer?

5. What are the treatment options that are being considered?

6. What treatment decision requires input from testing?

7. Specific tests planned (List tests planned and time required for each test i.e. Rorschach 2hrs, Thermatic Apperception Test 1 hour, etc.)

8. Total Hours Requested (0 to 10)

Please note: Deferred Diagnosis NOT accepted for Family Support Teams (FST), Methadone Maintenance or Ambulatory Detox.

AIS RE-REGISTRATION/CONCURRENT REVIEW FIELDS

(Outpatient, Home Based Services, Methadone Maintenance)

1. Indicate Degree of Progress from previous registration: ☐ None ☐ Minimal ☐ Moderate ☐ High

2. Indicate current level of stability: ☐ Not Stable ☐ Somewhat Stable ☐ Stable

3. Indicate proximity to baseline ☐ Not Close to Baseline ☐ Close to Baseline

4. Currently receiving psychotropic meds? ☐ Yes ☐ No *If Yes, select all class(es) of meds that apply:*
   ☐ Antidepressant ☐ Antipsychotic ☐ Mood Stabilizer ☐ Antianxiety ☐ Stimulant ☐ Prescribed Pain Reliever

5. Has a documented decision taken place with member (or his/her guardian) about the effectiveness of treatment and progress being made? ☐ Yes ☐ No #

6. Does a documented goal oriented treatment plan exist? ☐ Yes ☐ No

7. Members current symptoms: ***(Select all that apply)***
   ☐ Suicidal Ideation ☐ Suicide Attempt ☐ Disassociative ☐ Homicidal Ideation ☐ Physically Assaultive
   ☐ Verbally Aggressive ☐ Psychotic Symptoms ☐ Substance Abuse/Depend ☐ Self injurious behaviors ☐ Firesetting
   ☐ Intrusive Flashbacks ☐ Depression ☐ Elevated Mood ☐ PTSD/Trauma ☐ Beh.Problems/School/Home
   ☐ Anxiety ☐ Symptoms Stabilized

8. Risk factors: ***(Select all that apply)***
   ☐ Access to weapons ☐ History(Hx) of violence ☐ Hx of homicidal ideation ☐ Family violence ☐ Hx of explosive/impulsive beh.
   ☐ Hx of self injury ☐ Hx of suicidal ideation ☐ Hx of serious suicide attempts ☐ Hx of Sexual abuse ☐ Hx of unsuccessful tx
   ☐ Financial ☐ Medical condition ☐ Psychosis ☐ High Sub Abuse Relapse Risk ☐ Recent significant loss
   ☐ Sole caretaker of family member ☐ Unstable housing ☐ Legal Issues ☐ DCF Involvement ☐ Psychiatric/SA issue w/Parent/caretaker
   ☐ Separation from parent ☐ Hx of severe neglect/abuse ☐ Hx. of trauma ☐ Family Dysfunction ☐ Other

9. AXIS I – V Axis I Diagnosis Date: ____/_____/_____
   AXIS I & II: AXIS I _____ (circle one: Primary, Secondary, Rule Out)
   AXIS I _____ (circle one: Primary, Secondary, Rule Out)
   AXIS II (if deferred, pls indicate)_____ (circle one: Primary, Secondary, Rule Out)
   AXIS II _____ (circle one: Primary, Secondary, Rule Out)

10. AXIS III: ☐ None ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Cardiac Problem ☐ Chronic Pain ☐ Cystic Fibrosis
    ☐ Eating Disorder ☐ HIV ☐ Hearing Impairment ☐ Hepatitis ☐ Lupus ☐ Mobility impairment
    ☐ Neurological disorder ☐ Obesity ☐ Pregnancy ☐ Post-partum ☐ Sickle Cell ☐ Traumatic Brain Injury
    ☐ Type I Diabetes ☐ Type II Diabetes ☐ Visual impairment ☐ Other Axis III _____

11. AXIS IV: _____

12. AXIS V *(Indicate GAF Score 1-100)* _____

13. Treatment modalities to be used for this request? ☐ Individual ☐ Family ☐ Group ☐ Med Management

If Member is 18 or below, please complete the following:

During 90 days prior to this request for re-authorization has:

14. Member been enrolled in school? ☐ Yes ☐ No, Graduated ☐ No, Expelled ☐ No, Dropped Out
   a. If yes: Member been suspended from school?: ☐ Yes ☐ No
   b. Member had unexcused attendance problems?: ☐ Yes ☐ No

15. Member's behavior resulted in new legal problems?: ☐ Yes ☐ No ☐ Don't Know

16. Any new legal charges brought against member?: ☐ Yes ☐ No ☐ Don't Know

17. Family member been involved in any peer support activities? ☐ Yes ☐ No ☐ Not Applicable

18. Member been actively involved in any organized recreational activities?: ☐ Yes ☐ No ☐ Don't Know

19. Does the child's care plan include a goal of involvement in organized recreational activities?: ☐ Yes ☐ No ☐ Don't Know

20. During past 3 months, have you communicated w/ PCP or other medical provider?: ☐ Yes ☐ No

21. During past 3 months, have you communicated w/any of the following regarding care and treatment of Member?
    a. School ☐ Yes ☐ No ☐ Child not enrolled in school
    b. DCF ☐ Yes ☐ No ☐ Child not DCF involved
    c. Probation/Parole ☐ Yes ☐ No ☐ Not involved w. Probation/Parole

METHADONE MAINTENANCE

(CORE RE-REGISTRATION FIELDS (Pg 3-4) plus THE FOLLOWING)

1. How long has the member received methadone services? ☐ 6 mos or less ☐ 7 mos – 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs

2. Services included in treatment plan? ☐OP Therapy ☐Comm. Supp. (NA/AA) ☐IOP/PHP ☐Other BH Services ☐PCP/MD f/u

3. What is the ultimate treatment goal? ☐ Methadone Maintenance ☐ Abstinence

AMBULATORY DETOX

(Only initial registrations are allowed for ambulatory detox – providers requiring concurrent reviews for this level of care fax a request for concurrent reviews and these are completed with an internal AIS Custom Form))