Connecticut BHP
Supporting Health and Recovery

CT BHP REGISTRATION TEMPLATE

Provider EDS/CMAP ID # (Medicaid 9-digit ID) _____

Name of clinician who filled out this form _____Credentials/Title _____

Contact number _____ Ext:_____

Facility/Provider Name_____ Telephone Number_____

Facility/Provider Service Location _____

Member Name _____

Medicaid/Consumer ID# _____DOB: _____ *AND/OR* SSN: _____

LEVEL OF CARE: ☐ **Intensive Outpatient** ☐ **EDT** ☐ **Outpatient** ☐ **Methadone Maintenance** ☐ **Ambulatory Detoxification**
Home Based Services ☐ **IICAPS** ☐ **MDFT** ☐ **MST** ☐ **FFT**

QUESTIONS:

1. *** Requested start date** (EX: 09/01/2010): _____
2. *** Is this a new registration for a client already in outpatient treatment within your agency/practice?** ☐ YES ☐ NO
3. *** Is member stepping down to outpatient from a higher level of care within your agency/practice?** ☐ YES ☐ NO ☐ N/A
4. *** Referral Source:** (who encouraged this member to obtain services?)
   ☐ Community Collaborative ☐ Court-Ordered/Legal ☐ CT BHP ASO ☐ DCF ☐ DDS ☐ DMHAS ☐ EMPS
   ☐ Hospital Emergency Dept ☐ Other ☐ Other BH Provider ☐ PCP / Medical Provider ☐ School
   ☐ Self / Family Member ☐ Step Down Inpatient /Intermediate LOC
5. ***First phone or walk-in contact with member or parent/guardian**: Date_____
6. ***First contact was:** ☐ Telephone ☐ Walk-in
7. ***Referral type:** ☐ Emergent ☐ Routine ☐ Urgent
   a. **If Routine or Urgent:**
      Date of 1st Appt. Offered to Member: _____ Date of 1st Appt. Accepted by Member: _____
      Date of 1st Face-to-Face Clinical Evaluation: _____
      If Applicable, Number of no-shows/cancellations prior to first appt? **(Indicate #)** _____
   b. **If Emergent :** Date and Time Presented at the Clinic: ____/_____/_____ DATE _____ AM / PM
      Date and Time of Clinical Evaluation: ____/_____/_____ DATE _____ AM / PM
8. **AXIS I & II:**
   a. ***AXIS I** _____ Description: _____
   b. **AXIS I** _____ Description: _____
   c. **AXIS II** _____ Description: _____
   d. **AXIS II** _____ Description: _____
9. **AXIS III** ***(Select all that apply)***
   ☐ None ☐ Allergies ☐ Alzheimer's Disease ☐ Anemia ☐ Arthritis or Rheumatism ☐ Asthma ☐ Cancer or Leukemia
   ☐ Cardiovascular Problems ☐ Chronic Pain ☐ Chronic Obstructive Pulmonary Disease
   ☐ Circulation Problems in Arms and Legs ☐ Diabetes ☐ Disabilities or Physical Impairments (E.G., Blind)
   ☐ Emphysema or Chronic Bronchitis ☐ Epilepsy /Seizures ☐ Fibromyalgia ☐ Glaucoma
   ☐ High Blood Pressure (Hypertension) ☐ Head Injury ☐ HIV / AIDS ☐ Kidney Disease ☐ Liver Disease
   ☐ Migraine Headaches ☐ Multiple Sclerosis ☐ Obesity ☐ Parkinson's Disease ☐ Pregnancy
   ☐ Skin Disorders (Severe Burns, Leg Ulcers, etc.) ☐ Speech Impediment or Impairment
   ☐ Stomach GI Problems (E.G., Acid Reflux, Ulcers) ☐ Stroke / Effects of Stroke ☐ Thyroid or Other Glandular Disorders
   ☐ Urinary Tract or Prostate Problems ☐ Medical Condition Seriously Impacting Member's Health ☐ Unknown

10. AXIS IV (Check all that apply)

☐ None ☐ Educational problems ☐ Financial problems ☐ Housing problems ☐ Occupational problems

☐ Other psychosocial and environmental problems ☐ Problems with access to health care services

☐ Problems related to interaction with legal system / crime ☐ Problems with primary support group

☐ Problems related to social environment ☐ Unknown

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

12. Current Risks

Key: 0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

A. *Members Risk to Self 0 ☐ 1 ☐ 2 ☐ 3 ☐ ☐ N/A **B. *Members Risk to Others** 0 ☐ 1 ☐ 2 ☐ 3 ☐ ☐ N/A

13. Current Impairments

A. *Mood Disturbances (Depression or Mania)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

B. *Weight Changes Associated with Behavioral Diagnosis
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
For 2 or 3 rating:
Weight ☐ Gain ☐ Loss ☐ N/A
Past 3 mos _____ Lbs ☐ N/A
Current Wt _____ Lbs ☐ N/A
Height _____ Ft _____In ☐ N/A

C. *Anxiety
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

D. *Psychosis / Hallucinations / Delusions
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

E. *Medical / Physical Conditions
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

F. *Thinking/Cognitive/Memory/Concentration Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

G. *Substance Abuse / Dependence
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
For 2 or 3 rating: Check all that apply
☐ Alcohol Illegal ☐ Drugs ☐Prescription Drugs

H. *Impulsive/Reckless/Aggressive Behavior
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

I. *Job/School/Performance Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

J. *Activities of Daily Living Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

K. *Social Functioning/Relationships/Marital/Family Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

L. *Impairments Related to Loss/Trauma
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

M. *Legal
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
For 1, 2 or 3 rating: Check all that apply
☐ Juv Jus ☐ Probation ☐ Parole ☐ Other Court

14. Does member have co-occurring mental health and substance abuse conditions?
☐ Yes ☐ No ☐ Not Assessed

Treatment Plan

15. *Is psychiatric medication evaluation or medication management visit indicated? ☐ Yes ☐ No

16. *Have you provided information regarding Peer Support or Self Help Options? ☐ Yes ☐ No

17. *Do family members or significant others actively participate in the members treatment or recovery?

☐ Yes ☐ No

If yes, are any of the family members/significant others receiving their own MH or SA treatment? ☐ Yes ☐ No

18. Have you obtained consent to contact:

a. *School: ☐ Yes ☐ No ☐ Denied ☐ Adult not attending school

b. *Medical provider: ☐ Yes ☐ No ☐ Denied

c. *Previous behavioral health treatment provider: ☐ Yes ☐ No ☐ Denied ☐ N/A

19. *The treatment plan was developed with the member (or his/her guardian) and has measurable time limited goals.

☐ Yes ☐ No

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

21. *Anticipated / Target Date for achievement of current treatment plan goals _____

SPECIAL POPULATIONS

FEDERAL REPORTING REQUIREMENTS *ONLY* FOR MEMBERS 0-18 YEARS OF AGE

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

23. Co-Occurring Disorder: ☐ YES ☐ NO ☐ UNKNOWN

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

25. Within the past 12 months has the child/youth been arrested? ☐ YES ☐ NO ☐ UNKNOWN

26. Within the past 12 months has the child/youth been suspended / expelled? ☐ YES ☐ NO ☐ UNKNOWN

ADDITIONAL REQUIRED QUESTIONS *ONLY* FOR METHADONE MAINTENANCE/AMBULATORY DETOX:

Methadone Maintenance

*** 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 >

***What other services are included in the treatment plan?**

☐ Community Support (AA/NA) ☐ IOP/PHP ☐ Other Behavioral Health Services ☐ Outpatient Therapy
☐ PCP / MD Follow-up

***What is the ultimate treatment goal?** ☐ Abstinence ☐ Methadone Maintenance

Ambulatory Detox

***From what substance is the member in need of detoxification? (select all that apply)**

☐ Alcohol ☐ Benzodiazepines ☐ Opiates

***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+

***What is the identified discharge plan? (Select all that apply)**

☐ Community Support (AA/NA) ☐ IOP/PHP ☐ Methadone Services ☐ Other Behavioral Health Services
☐ Outpatient Therapy ☐ PCP/MD Follow-up