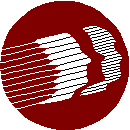
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**DSAMH Behavioral Health Substance Use Disorder (SUD)**

**Authorization Request Form**

**Send Request to:** [**DSAMH\_EEU\_SUD@delaware.gov**](mailto:DSAMH_EEU_SUD@delaware.gov)

**Information that is not legible or incomplete will potentially delay authorization.**

|  |  |
| --- | --- |
| **Consumer’s Name** |  |
| **Consumer’s MCI Number & SS #** |  |
| **Consumer’s Date of Birth** |  |
| **Name of Treatment Facility**  **Phone Number**  **Address (city & zip code only)** |  |
| **Person Completing Form** |  |
| **Contact Person at Facility**  **(include phone # & email address)** |  |
| **Requested Start Date** |  |
| **Admitting Physician** |  |
| **Requested ASAM Level of Care** |  |
| **Health Insurance** | **\_\_ NONE \_\_FFS**  **\_\_ PROMISE MEMBER** |

**AUTH Request Type: \_\_ INITIAL \_\_ CONTINUED STAY**

**Is member under the influence of drugs or alcohol at time of admission?**

**\_\_Yes ­\_\_ No**

**Presenting Problem**

|  |
| --- |
|  |

**Continued on Page 2**

**Page 2 – DSAMH BH (Substance Abuse) Authorization Request From**

**Consumer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinical Information (Current Withdrawal Symptoms/Vital Signs/WAS/COWS, attach additional documents as needed)**

|  |
| --- |
|  |

**Drug Screen Results**

|  |
| --- |
|  |

**Is This a Readmission? \_\_ Yes \_\_ No**

**If Yes – list last admission/discharge dates**

**List All Diagnoses**

|  |
| --- |
|  |

**Substance Use History (Amount, Duration, Frequency, Last Use)**

|  |
| --- |
|  |

**Continued on Page 3**

**Page 3 – DSAMH BH (SUD) Authorization Request form**

**Consumer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Medications**

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Prior Substance Use Treatment History (Facility, Dates, Clean Time)**

|  |
| --- |
|  |

**ASAM Criteria**

|  |  |  |
| --- | --- | --- |
|  | **Level of Care** | **Risk Level & Criteria Indicated** |
| **DIMENSION I:** |  |  |
| **DIMENSION II:** |  |  |
| **DIMENSION III:** |  |  |
| **DIMENSION IV:** |  |  |
| **DIMENSION V:** |  |  |
| **DIMENSION VI:** |  |  |

**Continued on Page 4**

**Page 4 – DSAMH BH (SUD) Authorization Request Form**

**Consumer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treatment Plan and Orders with this Admission / Number of Days Requested**

|  |
| --- |
|  |

**Potential Barriers to Discharge / Stressors**

|  |
| --- |
|  |

**Does Consumer Have Family/Informal Supports □ Yes □ No**

**List:**

|  |
| --- |
|  |