Cover Sheet for Referring to a Higher Level of Care (LOC)

Fax to the appropriate CHMSHP Access Center.

For Submitting a Client to Be Approved for ST, LT or Sub-Acute Detox Residential			
Client Name:		Client Address:	
Client Birthdate:		Agency Submitting Clinician name and contact info:	
Client SSN:			
Client Phone #		Referred to:	
Funding: Medicaid Block Grant HMP Ability to Pay $ (monthly)			

DSM IV Diagnosis Information	
Axis I Primary Diagnosis	
Secondary Diagnosis	
Axis I Primary Diagnosis	
(MH) Secondary Diagnosis	
Comments:	
Axis II Primary Diagnosis	
Secondary Diagnosis	
Axis III	

AXIS IV (Check all that apply)			
Problems w/ primary support group		Problems related to legal system	
Occupational Problems		Educational problems	
Problems with Access to Health Care		Economic problems	
Problems related to social environment		Other (if selected Other please describe below.)	
Housing problems			
Axis V -GAF Score:			
Presenting Problem:			

ASAM PPC Information									
	.05	1	II.1	II.5	III.1	III.3	III.7	OMT	Sub-Acute Detox
1. Acute Intox and/or Withdrawal Potential									
Evidenced by:									
2. Biomedical Conditions And Complications (Unrelated To Withdrawal)									

LAKESHORE REGIONAL PARTNERS

Evidenced by:									
3. Emot./Beh. Conditions & Complications									
Evidenced by:									
4. Treatment Acceptance/Resistance									
Evidenced by:									
5. Relapse/Continued Use Potential									
Evidenced by:									
6. Recovery Environment									
Evidenced by:									
ASAM PPC Level of Care Indicated:			ASAM PPC Level of Care Requested:						
Comments:									