Clark County Regional Support Network

Inpatient Voluntary Authorization Form

CALLER INFORMATION **TYPE OF AUTH:** ❑ Standard ❑ Retroactive Review

Date:_____ Time of Call or Page:_____AM/PM Time of CM Response:_____AM/PM

Name of Caller:_____ Title/Credential:_____

Agency:_____ Phone:_____

Date of Patient Evaluation:_____ Time of Patient Evaluation:_____

NAME of PATIENT:_____ DOB: :_____

Axis V GAF: _____ Current Medications:_____

Prescribed By:_____ Agency:_____

Current Substance Abuse? ❑ NO ❑ YES Identify Substance(s):_____

Current Substance Abuse Treatment? ❑ NO ❑ YES Where/Agency?_____

Current Outpatient Treatment? ❑ NO ❑ YES Where/Agency?_____

PCP/CM Consulted? ❑ NO ❑ YES Name:_____

History of Suicidal/Homicidal Gesture/Attempts? ❑ NO ❑ YES *If yes, describe*:_____

History of Hospitalization? ❑ NO ❑ YES *If yes, describe*:_____

MEDICAL NECESSITY (Risk Assessment/Acuity/Function/Support/Environment/Alternatives Explored) _____

GOAL(s) FOR HOSPITALIZATION: _____

INPATIENT AUTHORIZATION CRITERIA - Person must meet criteria 1 or 2 **AND** 3 through 6:

1. ☐ Patient is exhibiting imminent risk of suicide or homicide due to a mental disorder.

OR

2. ☐ Patient is not intoxicated OR there is documented evidence that mental health symptoms would persist beyond intoxication.

AND ALL OF THESE (3-6)

3. ☐ Patient is functionally impaired and presenter is able to provide evidence of extreme functional impairment.
4. ☐ Less restrictive mental health alternatives have been ruled out based on clinical considerations and availability of resources.
5. ☐ The primary symptoms are consistent with a covered mental health condition.
6. ☐ The hospitalization does not appear to be related to a need for housing, community support or urgent access to outpatient services.

IF DIVERTED

Plan:_____

Hospital agrees with diversion? ❑ Yes ❑ No = **DENIED-Go to Psychiatric Consultation and Expedited Review Form**

AUTHORIZATION DECISION DATE: Date:_____ Time:_____AM/PM Care Manager:_____