**BEHAVIORAL HEALTH — LEVEL OF CARE REQUEST FORM**

***For Eating Disorders level of care requests, complete the relevant supplemental section on page 2.***

**Please type an “x” or type content as needed in the gray boxes only.**

***NOTE: Text boxes will not expand beyond the space available***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MEMBER NAME: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DOB (MM/DD/YYYY): | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Gender: Other: |  | Male |  | Female | Other : |  |   GENDER: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insurer: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Policy #: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Requesting Clinician/Facility: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone #: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | NPI / TIN#: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Servicing Clinician/Facility: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone #: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | NPI / TIN#: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Currently in an ER: | | | | | | | | | | | | |  | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | | | | | | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date and Time of Request (MM/DD/YYYY): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Service Date for Request (MM/DD/YYYY): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LEVEL OF CARE REQUESTED** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Inpatient | | | | | | | | | |  | | | | | | | Partial Hospitalization | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | Community Stabilization/Treatment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( | | | | | | | | | | ICBAT | | | | | | | | | |  | | | | | | | | | | CBAT | | | | | | | | |  | | | | | | | | CCS/CSU) | | | | | | | | | | | | | | | |
|  | Residential | | | | | | | | | | | | |  | | | | | | | | Outpatient Psychotherapy (except 90837/90838) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | 90837/90838: | | | | | | | | | | | | | | | | | | | | | | ( | | | | | | | | | ACT | | | | | | | | | | |  | | | | | | | | | CBT | | | | | | | | |  | | | | | | | | Cognitive Processing | | | | | | | | | |
|  | DBT**E** | | | | |  | | | | | | EMDR | | | | | | | |  | | | | | | | | | | Exposure | | | | | | | | | | | | | | |  | | | | | | | | | Functional Family | | | | | | | | | | | | | | | | | |  | | | | | | | PCIT | | | | | | | | | |  | | | | | | | | IPT | | | | | | | |  | | | | | | | | | | Other:      ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Family Stabilization | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SERVICE TYPE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Behavioral Health | | | | | | | | | | | | | | | | |  | | | | | | | | | BH in General Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | Dual Diagnosis | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | Eating Disorder | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CHIEF COMPLAINT/REASON FOR REQUEST/DIAGNOSES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Chief Complaint/Reason for Request** (Frequency, intensity, duration of symptoms) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | mild | | | | | | | | |  | | | | | | | | | | | | moderate | | | | | | | | | |  | | | | | severe | | | |
|  | acutely life threatening: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Are there any functional impairments? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Yes | | |  | | | | No | |
| Medications: | | | | | | | | |  | | | | | None | | | | | | |  | | | | | | | | | | | antidepressant | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | antianxiety | | | | | | | | | | | | | | | | |  | | | | | | | | | | | antipsychotic | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | mood stabilizer | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | stimulant | | | | | | | | | |  | | | | | | | | Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary Psychiatric diagnosis:** | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ICD/DSM Code: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Secondary Psychiatric diagnosis: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ICD/DSM Code: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Substance Use Disorder diagnosis:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ICD/DSM Code: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Relevant active medical problems? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | Yes | | | | | | | |  | | | | | | | | | No | | | | | Medically cleared? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | Yes | | | | | | | | | |  | | | | | | | | | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Needs further evaluation/intervention? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Yes | | | | | |  | | | | | | | | | | | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Relevant Active Medical diagnoses:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ICD Code: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prior Admissions: | | | | | | | | | | | | |  | | | | | | | Yes | | | | | | | |  | | | | | | | | | | No | | | | | | | |  | | | | | | | | | Unknown | | | | | | | | | | | | | | | | | INPATIENT: | | | | | | | | | | | | | | | | | | # of times | | | | | | | | | | | | | |  | | | | | | | | | | most recent (mm/dd/yyyy) | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| SUBSTANCE USE/DETOX: | | | | | | | # of times | | | | | | | | | | |  | | | | | | | | | most recent (mm/dd/yyyy) | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | OTHER: (specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | # of times | | | | | | | | | | | | | | |  | | | | | | | | | | most recent (mm/dd/yyyy) | | | | | | | | | | | | | |  | | | | | | |
| **MEDICAL/PSYCHOSOCIAL RISKS AND FUNCTIONAL IMPAIRMENTS *(select all that apply to the current request)*:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Suicidal: | | | | | | | |  | | | | | Current Ideation | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | Active Plan | | | | | | | | | | | | | | | | |  | | | | | | | | | Current Intent | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | Access to Lethal Means | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | None | | | | | | |
|  | | | Section 12 | | | | | | | | | | |  | | | | | | | Current Suicide Attempt | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | Prior Suicide Attempt (<1 year) Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Homicidal/Violent: | | | | | | | | | | | | |  | | | | | | | Current Ideation | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | Active Plan | | | | | | | | | | | | | | | | | |  | | | | | | | | Current Intent | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | Access to Lethal Means | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | None | | |
|  | Current Threat to Specific Person | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | Prior Violent Acts (<1 year) Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Self-Care   /ADLs: | | | | | | | | | |  | | | | | | | mild | | | | | | | | |  | | | | | | | | | moderate | | | | | | | | | | | | | | | |  | | | | | | | | | severe | | | | | | | | | | | |  | | | | | | | acutely life-threatening Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Highest and Lowest Levels of Functioning (<1 year): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Self-Injurious Behavior: | | | | | | | | | |  | | | | | | | mild | | | | | | |  | | | | | | | | | | moderate | | | | | | | | | | | | | | |  | | | | | | | | | severe | | | | | | | | | | | |  | | | | | | | | acutely life-threatening Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Agitated/Aggressive Behavior: | | | | | | | | | | | | | | |  | | | | | | | | mild | | | | | | | |  | | | | | | | | | moderate | | | | | | | | | | | | | | | |  | | | | | | | | severe | | | | | | | | | | |  | | | | | | | | | acutely life-threatening Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Medication Adherence: | | | | | | | | |  | | | | | | Yes | | | |  | | | | | | | | | | No | | | | | | |  | | | | | | | | | Unknown | | | | | | | | | | | | |  | | | | | | | | | | Other Treatment Adherence: | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | Yes | | | | | | | |  | | | | | | | | | No | | | | | | Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Legal Issues, Court/DYS Involvement: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | Yes | | | | | |  | | | | | | | | | No | | | | | | | Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Employment Risks: | | | | | | | | | | | | | | | |  | | | | | | | | | employed | | | | | | | | | | | | | | |  | | | | | | | | | | employment at risk | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | on/requesting medical leave | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | disabled | | | | | | | | | | | | | | |
|  | | unemployed | | | | | | | | | | | | |  | | | | | | | | Other | | | | | | | | | | | | | | | | | | Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Psychosocial/Home environment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | supportive | | | | | | | | | | | | | | | | |  | | | | | | | | | | neutral | | | | | | | | | | |  | | | | | | | | | | | | directly undermining | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | home risk/safety concerns | | | | | | | | | | | | | | | | | |
|  | homeless | | | | | | | | | |  | | | | | | | lives alone | | | | | | | | | | | | | | | | |  | | | | | | | | | | married | | | | | | | | | | | | | | | | | | | |  | single | | | | | | | | | |  | | | | | | | | | | | divorced | | | | | | | | | | | | | |  | | | | | | | | | | separated | | | | | | | | | | | | | | |  | | | | | | | | dependents | | | | | | | | | | | | | | | |
|  | Other | | | | | | Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Additional Concerns: | | | | | | | | | | | | | | | | |  | | | | | | | | | Yes | | | | | |  | | | | | | | | | No | | | | | | | Explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Outpatient BH/SUD treatment in place? | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | Yes | | | | | | |  | | | | | | | | | | No | | | | | |  | | | | | | | | Unknown, Have the outpatient treaters been contacted? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Yes | | |  | | | | No |

**BH Level of Care: Supplemental — for Eating Disorders**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Eating Disorders level of care requests *(complete the following)*:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Level of Care: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Inpatient Eating Disorders Specialty Unit (medically unstable) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Partial Hospital Eating Disorders Program (weekdays, 9–2 or 9–5) | | | | | | | | | | | | | | | | |
|  | Acute Residential Eating Disorders Unit | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Intensive Outpatient Eating Disorders Program (several days per week, a few hours) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Partial Hospital Eating Disorders Program (seven days per week) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Outpatient Eating Disorder Program | | | | | | | | | | | | | | | | |
| Height: | | |  | | | | | | | | | | | | | | | Weight: | | | |  | | | | | | | | | | | | | | | | | | | BMI: | | | |  | | | | | | | % IBW: | |  | |
| Highest weight: | | | | | |  | | | | | | | | | | | | Lowest weight: | | | | | | | | | |  | | | | | | | | | | | | | Weight change in one month: | | | | | | | | | | |  | | | |
| **Orthostatic Vitals:** | | | | | | | | sitting BP: | | | | | | | / | | | | | | | | | | | PR: | | | | | | | |  | | | | | | | | standing BP: | | | | | | | / | | | | PR: | |  |
| **Labs**: | Potassium: | | | | | |  | | | | | | Sodium: | | | | | | |  | | | | | | | Relevant abnormal labs: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abnormal: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EKG: |  | | | | Yes | |  | | | | | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical Evaluation: | | | | | | | | |  | | | | Yes | | | |  | | | | No | | | If yes, when | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recent need for IV hydration: | | | | | | | | | | | | | |  | | | | | | Yes | |  | | | | | | No | | | If yes, when | | | | | | | | | | | | | | | | | | | | | | | | |
| Current Symptoms: | | | | | | | | | |  | | | | dizziness | | | | | | | |  | | | | | | | fainting | | | |  | | | palpitations | | | | | | | | | |  | | shortness of breath | | | | | | | |
|  | | amenorrhea | | | | | | | | |  | | | | | cold intolerance | | | | | | | | | | | | |  | | | vomiting blood | | | | | | | |  | | | | | | | | | | | | | | | |
| Current Behaviors: | | | | | | | | |  | | | | binging | | | | | | |  | | | | purging | | | | | | |  | | restricting | | | | |  | | | | | | over exercising | | | | | |  | None | | | | |
| Current Abuse of: | | | | | | |  | | | | | laxatives | | | | | | |  | | | | diuretics | | | | | | | |  | | diet pills | | | |  | | | | | | ipecac | | | |  | | None | | | | | | |
| Specify other pertinent symptoms, behaviors, or high-risk presentations: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

*\* This form is intended for fully-insured plans only. Not all carriers require prior authorization for the above services; not all levels of care are available in member benefit plans. Providers should consult the health plan’s coverage policies and member benefits.*

2