



**SUBMIT TO:**  
 Utilization Management Department  
 PHONE 1-866-534-5976 FAX 1-866-535-6974

# Substance Use Disorder (SUD) Initial Review Form (Adult)

Reviewed Clinical History (Previous Authorization, Impact Pro, etc.):  Yes  No

## BILLING PROVIDER

Facility: \_\_\_\_\_ UR/Phone #: \_\_\_\_\_ ASAMLOC: \_\_\_\_\_  
 Fax #: \_\_\_\_\_ NPI #: \_\_\_\_\_ Admit Date: \_\_\_\_\_  
 Tax ID #: \_\_\_\_\_ Voluntary or Involuntary: \_\_\_\_\_  
 Guardian: \_\_\_\_\_ Phone #: \_\_\_\_\_

## DIAGNOSTIC AND TREATMENT INFORMATION

Dx: \_\_\_\_\_  
 Attending MD: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Precipitating Event: \_\_\_\_\_

SUD HX/USE:	Substance	Age First Use	Amount	Frequency	Last Use

Tx Hx: \_\_\_\_\_

## UDS

UDS/BAL: \_\_\_\_\_  
 COWS/CIWA score (If Available): \_\_\_\_\_ At Admission: \_\_\_\_\_ Current: \_\_\_\_\_  
 Detox: \_\_\_\_\_  
 Withdrawl Sx: \_\_\_\_\_  
 Vitals (For IP Detox): \_\_\_\_\_

## MEDICAL HISTORY

Medical Hx: \_\_\_\_\_  
 Current Medicine Changes: \_\_\_\_\_  
 \_\_\_\_\_  
 OP Meds: \_\_\_\_\_  
 \_\_\_\_\_

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**PSYCHOLOGICAL HISTORY**

Psych Hx: \_\_\_\_\_  
SI/HI/AVH: \_\_\_\_\_  
Abuse/Trauma Hx: \_\_\_\_\_  
Family Hx: \_\_\_\_\_

**STATE OF CHANGE**

**TRIGGERS**

Triggers for Use: \_\_\_\_\_  
Longest Sobriety: \_\_\_\_\_

**SUPPORT SYSTEM**

Sober Support System: \_\_\_\_\_  
Lives With: \_\_\_\_\_  
Legal: \_\_\_\_\_  
Education: \_\_\_\_\_ Employment: \_\_\_\_\_  
Discharge Criteria: \_\_\_\_\_ Plan: \_\_\_\_\_  
Discharge Barriers: \_\_\_\_\_  
Discharge Planner: \_\_\_\_\_ Phone #: \_\_\_\_\_  
ELOS: \_\_\_\_\_  
Planned Therapeutic Leave Days Within Authorization Period (Where/Why):

**If Request Is Sent To Peer Review (P2P) Please Indicate:**

Name (DR/UR): \_\_\_\_\_ Phone #: \_\_\_\_\_  
Date/Time Within Next 24 Hours for P2P: \_\_\_\_\_