

**GHS INPATIENT PRE-ADMISSION REVIEW (IPAR) REQUEST FORM**

**Please fax to the GCCMH Utilization Management Department at (810) 496-4932**

To reach a Pre-admission Review Coordinator by phone, please call (810) 496-4931

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\*\* The patient must be assessed face-to-face on the same day this prescreen form is sent for Utilization Management review, and the consumer must be present at the time Utilization Management makes a determination (a determination will be made within 3 hours of receipt of a prescreen) – include the date/time that the prescreen assessment was completed

\*\* The person completing the prescreen assessment must be a professional with one of the following credentials: psychiatrist, physician, physician assistant, nurse practitioner, clinical nurse specialist, masters- or doctoral-level psychologist, master’s level social worker, master’s level licensed professional counselor, master’s level marriage and family therapist, or registered nurse – include the name and credentials of the person completing the prescreen assessment and a phone number where this person can be reached up to 3 hours upon Utilization Management receipt of the prescreen for further questions and/or to provide the disposition of the review and/or direction for making a referral for crisis services authorized

\*\* If an appropriately credentialed professional is not available to complete the prescreen assessment, the patient may be referred to Genesee Health System Behavioral Health Urgent Care for a virtual clinical assessment/crisis screen 24/7/365 (or face to face during walk-in hours): 810-496-5500

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| **ADMISSION TYPE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Voluntary** | | | | | | | | | | | | | | | |  | | | | **Involuntary** | | | | | | | | | | | | | |
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| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient Name:** | | | | |  | | | | | | | | | | | | | | | | | **DOB:** | | | | | |  | | | | | | |
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| **REMAINING DEMOGRAPHIC INFORMATION (or**  **see faxed face sheet with IPAR)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | |  | | | | | | | | | | | | | | | | City/State: | | | | | | | | | |  | | |
| County of Res: | | | | | |  | | | | | | | | | | | | | | | | SSN: | | | | | | | | | |  | | |
| Home Phone: | | | | | |  | | | | | | | | | | | | | | | | Gender: | | | | | | | | | |  | | |
| Medicaid/MI Child ID#: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| AKA or other information: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **GUARDIAN INFORMATION (disregard if information appears on attached face sheet)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Guardian Name: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **PRIMARY CARE PHYSICIAN (disregard if information appears on attached face sheet)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Care Physician: | | | | | | | | |  | | | | | | | | | | | | | | | | Phone: | | | | | |  | | | |
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| **PRESENTING PROBLEM** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **PATIENT HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| History of mental health treatment: | | | | | | | | | | | | | |  | | | | | | None | | |  | | | Unknown | | | | | | | |
| Psychiatric Inpatient? | | | | | | | | | | | Yes | | | | No | | | | | | | | | | | | | | | | | | | |
| Mental Health Outpatient? | | | | | | | | | | | Yes | | | | No | | | | | | | | | | | | | | | | | | | |
| |  |  | | --- | --- | | Previous Psychiatric Diagnosis: |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SUBSTANCE ABUSE HISTORY (list in order of choice beginning with first drug of choice)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type/Name: | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | |
| Current consumption | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | |
| Date last used | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | |
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| **CURRENT IMPAIRMENTS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | None | | | Mild | | | | | Moderate | | | | | | Severe | | | | | Comments | | | | | |
| Mood disturbance | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Anxiety | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Psychosis | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Thinking/Cognition/memory | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Impulsive/reckless/aggressive | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Activities of daily living | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Weight change assoc w/behav. dx. | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Medical/physical condition | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Substance abuse/dependence | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Job/school performance | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Social/marital/family prob. | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
| Legal | | | | | | | | | |  | | |  | | | | |  | | | | | |  | | | | |  | | | | | |
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**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 2**

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| **RISK FACTORS** | | | | | | | | | | | | | | | | | | | | | |
| To Self (SI) | | | w/ideation | | | | | | w/intent | | | | | w/plan | | | | w/means | | | |
| Describe: | |  | | | | | | | | | | | | | | | | | | | |
| To Others (HI) | | | w/ideation | | | | | | w/intent | | | | | w/plan | | | | w/means | | | |
| Describe: | |  | | | | | | | | | | | | | | | | | | | |
| Current attempts? | | | | | | Yes  No | | | | If yes,  SI or  HI | | | | | | | Date: | | | | |
| Describe: | |  | | | | | | | | | | | | | | | | | | | |
| Prior attempts? | | | | | | Yes  No | | | | If yes,  SI or  HI | | | | | | | Date: | | | | |
| Describe: | |  | | | | | | | | | | | | | | | | | | | |
| Prior gestures? | | | | | | Yes  No | | | | If yes,  SI or  HI | | | | | | | Date: | | | | |
| Describe: | |  | | | | | | | | | | | | | | | | | | | |
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| Other factors: | | | | | (specify checked boxes in details) | | | | | | | | | | |  | | | | | |
| Lack of support | | | | | | | Unstable living arrangement | | | | | | | | | | | | | | |
| Recent Loss | | | | | | | Current Substance Abuse | | | | | | | | | | | | | | |
| Past aggression | | | | | | | Marked or severe ADL’s | | | | | | | | | | | | |  | |
| Hopelessness | | | | | | | Recent Psychiatric Inpatient Discharge | | | | | | | | | | | | |  | |
| History of Abuse  Medical Health Risks | | | | | | | Family History of Suicide | | | | | | | | | | | | |  | |
| Dangerousness: | | | | | | Self | | Others | | | | | Inability to care for self | | | | | | | | |
|  | | | | | | Inability to recognize need for tx | | | | | | | | | | | | | | | |
| **Overall risk rating:** | | | | | | | **None** | | | | **Mild** | | | | **Moderate** | | | | **Severe** | |
| ****Details: |  | | | | | | | | | | | | | | | | | | | | |
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| |  | | --- | | **ADDITIONAL INFORMATION AND COMMENTS** | |  | |  | |  | |  | |  | |  | |  | | | | | | | | | | | | | | | | | | | | | | |
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| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **DIAGNOSIS** | | | | | | | | |  | **DSM-IV** | | **Description** | | | |  | | Primary |  |  | |  | | Rule out | | | Secondary |  |  | |  | | Rule out | | |  |  |  | | |  |  | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **DRUG SCREEN:** | | | | | | | | UDS: YES  NO | | If yes, date: | | |  | | | **** If yes, outcome: | Pending | | | Negative | | Positive | | **** If positive, for what? : | | |  | | | | |

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| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **PHYSICIAN’S RECOMMENDED DISPOSITION** | | | | | | | | | |  | | | | | | | | | | Inpatient admission | | Facility: | |  | | | | | | Crisis Residential | Partial Hospital Program | | | | | | Crisis Stabilization | | |  | | | | |  | | | | | Physician Name: | | | | |  | | | | |  | | |  | | |  | |  | | **Who should UM should contact for related discussion:** | | | | | | | | | | Name and Credentials of Professional Completing Face-to-Face Assessment:  Hospital/Agency Name:  Contact Person’s Name: | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Contact Person’s Phone #: | | | | |  | | | | | (must be available for next 3 hours)  Contact Person’s Fax #: | | | | |  | | | | |
| |  |  | | --- | --- | | **Date of Request:** |  |  |  | | --- | | **Time of Request:** |   \*\*Utilization Management has up to 3 hours from the time an IPAR is received to review and make a determination. If you do not receive a response from our team within 1 hour of sending, please call the prescreen line at (810) 496-4931 and confirm receipt of your faxed review form |