

**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:** |  |
|  |  |  |  |
| **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: |  |
|  |  |
| **PRIMARY CARE PHYSICIAN (disregard if information appears on attached face sheet)** |
| Primary Care Physician: |  | Phone: |  |
|  |
| **PRESENTING PROBLEM** |
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| **PATIENT HISTORY** |
| History of mental health treatment: | [ ]  | None | [ ]  | Unknown |
| Psychiatric Inpatient?  | [ ]  Yes | [ ]  No |
| Mental Health Outpatient?  | [ ]  Yes | [ ]  No |
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| Previous Psychiatric Diagnosis: |  |

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| **SUBSTANCE ABUSE HISTORY (list in order of choice beginning with first drug of choice)** |
| Type/Name: |  |  |  |
| Current consumption |  |  |  |
| Date last used |  |  |  |
|  |  |
| **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:  |  |
|  |  |  |  |
| 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 |
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| **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 #: |  |

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| **Date of Request:** |  |

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| **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 |