

Quest Behavioral Health (SA)

PLEASE RETURN VIA FAX TO (717) 851-1414 or MAIL TO QUEST PO BOX 1032 YORK, PA 17032

Outpatient Substance Abuse

Today's Date: _____

_____90806SA _____90847SA _____90853SA

New Case

*Please indicate the number of each sessions you are requesting.

Start date: _____

Recertification

Patient Name: _____

Date of Birth: _____ ID #: _____

Type of Insurance: _____

Clinician providing information and contact telephone number: _____

Office/Group: _____ Location: _____

Current Diagnosis: _____

Current Meds or Changes in Meds: _____

Show Level of Care indicated for each Dimension below

		<u>Level of Care</u>
1.	Intoxication/Withdrawal	_____
2.	Biomedical Conditions	_____
3.	Emotional/Behavioral	_____
4.	Readiness to Change	_____
5.	Relapse Potential	_____
6.	Recovery/Environment	_____

A comment about the client's progress/status is required for each Dimension.

Dimension 1: _____

Dimension 2: _____

Dimension 3: _____

Dimension 4: _____

Dimension 5: _____

Dimension 6: _____

Patient in agreement of above treatment plan and/or level of care YES NO

If not, what is patient's request for Treatment/LOC _____