

**CHEMICAL DEPENDENCY OUTPATIENT AND INTENSIVE OUTPATIENT (IOP)  
TREATMENT PLAN — REQUEST FOR DETERMINATION OF MEDICAL NECESSITY**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ PacificSource ID: \_\_\_\_\_

**PRACTITIONER INFORMATION**

Name: \_\_\_\_\_ License type: \_\_\_\_\_ Tax ID Number: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Case Manager: \_\_\_\_\_

**TREATMENT INFORMATION**

**DSM IV:** \_\_\_\_\_ **Disorder:** \_\_\_\_\_ (Please include DSM IV code and name of disorder.)

**Is this a court-mandated diversion program?**  Yes  No

- ASAM Level:**
- Dimension 1: Detox/withdrawal potential
  - Dimension 2: Physical health risks/complications
  - Dimension 3: Emotional, behavioral, cognitive conditions/complications
  - Dimension 4: Readiness to change
  - Dimension 5: Relapse, continued use, or continued problem potential
  - Dimension 6: Recovery/living environment

**Case summary:** (Identify the problems and priorities that determine the proposed level of care.) **Attach initial evaluation with case history and clinical impression.**

**TREATMENT RECOMMENDATION**

- Adult  Level 1: Outpatient
- Adolescent  Level 2: Intensive outpatient (IOP)

\_\_\_\_ Group(s) per week + \_\_\_\_ Hour(s) of individual/family treatment per week = \_\_\_\_\_ visits  
\_\_\_\_ Hours per group      \_\_\_\_ **Total individual/family treatment hours/week**  
\_\_\_\_ **Total Group Hours/week**

**Time Frame:** \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ Total number of visits proposed: \_\_\_\_\_

**CONTACT INFORMATION**

Contact person/clinic/provider: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_