



# KINGSTON TRUST FUND

## Utilization Management

PRE-CERT CO.:

HUGHES & ASSOC.

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ITR Form

### Mental Health/Substance Abuse Treatment Plan

Client Information	Provider Information
DATE OF ADMISSION:	NAME/FACILITY:
NAME:	SPECIALTY/CERTIFICATION:
INSURED:	ADDRESS:
ID #:	CITY:
ADDRESS:	STATE & ZIP:
CITY/STATE/ZIP:	DIRECT # TO CLINICIAN:
HOME PHONE:	FAX #:
CELL NUMBER:	TAX ID #:
BIRTH DATE:	<b>PRECERTIFICATION REQUEST</b>
AUTHORIZATION #: Fax ITR form to Nurse Review 72 HOURS AFTER ADMIT	
PRESENTING PROBLEMS: PRIMARY ICD 10: CPT CODE:	
SECONDARY:	
MENTAL STATUS DESCRIPTION:	
CURRENT MEDICATIONS:	

RISK ASSESSMENT:

IMPRESSION SUMMARY:

PERSONALITY DISORDER:

MENTAL RETARDATION:

PSYCHOSOCIAL, ENVIRONMENT, OCCUPATIONAL, EDUCATIONAL PROBLEMS:

CLINICAL DISORDER:

MEDICAL PROBLEMS OR DISEASE:

TREATMENT PLAN:

TREATMENT MODALITIES:

GOALS:

PROGNOSIS:

PROJECTED # OF DAYS:

GOALS MET FOR DISCHARGE: