



## Medical / Behavioral Health Clearance

An Authorization for Release of Protected Health Information (PHI) signed by the client **must** accompany this Clearance in order to disclose this information.

Client Name \_\_\_\_\_

Date \_\_\_\_\_

The client listed above has been assessed for:

- Withdrawal Management (Detoxification)     Residential Treatment

In order to effectively and safely administer services for the patient we request they obtain a Medical and/or Psychiatric clearance.

**A. Definitions and Treatment Environment**

**Withdrawal Management (Detoxification)**

American Society of Addiction Medicine (ASAM) Level:

- 3.2WM: Clinically Managed Residential Withdrawal Management:
  - Services are provided in a group setting
  - Service delivery – social setting withdrawal management program
  - Patients withdrawal signs and symptoms at this time do not require the full resources of a medically monitored inpatient withdrawal management facility
  - Protocols in place for transfer to high level of care when warranted

**Residential Treatment**

American Society of Addiction Medicine (ASAM) Level:

- 3.1 Clinically Managed Low-Intensity Residential Services
- 3.2 Clinically Managed Population Specific High-Intensity Residential Services
- 3.5 Clinically Managed High-Intensity Residential Services
  - Services are provided in a group setting (living/sleeping accommodations and group therapy)
  - Patient is ambulatory (able to self-groom, attend individual and group therapy/educational sessions, assist with daily living activities in a group setting, participate in recreational activities of their choice, etc.)

**B. Type of Clearance Requested**

Medical Clearance

Psychiatric Clearance

**C. Clearance – This section to be completed by provider**

**Medical Health Provider:** *please check the appropriate response*

**Medical Status**

At this time the severity of the patient's medical condition does not prevent them from participating in Withdrawal Management (Detoxification) and/or Residential Treatment Services.

At this time the severity of the patient's medical condition requires further consultation from a specialist and participation in Detoxification and/or Residential Treatment Services is **not** recommended.

**Behavioral Health Provider:** *please check the appropriate response*

**Psychiatric Status**

At this time the severity of the patient's psychiatric condition does not prevent them from participating in Detoxification and/or Residential Treatment Services.

At this time the severity of the patient's psychiatric condition requires further assessment by a licensed psychiatrist or psychiatric nurse practitioner and participation in Detoxification and/or Residential Treatment Services is **not** recommended.

**Medical Diagnoses**

**Psychiatric Diagnoses**


**Current Medications:**

*Please assist the treatment facility in maintaining continuity of care by prescribing non-narcotic medications whenever possible. Thank you*

Type	Dosage	Directions

**Additional Instructions**


LPHA/MD's Printed Name

Date

LPHA/MD's Signature

Phone Number

LPHA Consultant or Specialist's Printed Name

Date

LPHA Consultant or Specialist's Signature

Phone Number