Sandhills Center - Service Authorization Request (SAR)

Patient's Name:	
Social Security #:	DOB:
Current Address:	
City/State/Zip:	
Medicaid #: - - ☐ None	County (Medicaid Eligibility):
Attending Provider:	
Legal Guardian: ☐ None ☐ Parent ☐ DSS ☐ Other:	Name:

DIAGNOSES: Indicate Primary Diagnosis with (P).

DATE OF INITIAL ASSESSMENT and/or Subsequent Assessments prior to referral:
☐ MH ☐ SA ☐ DD ☐Voluntary ☐Involuntary
☐Initial Request ☐Reauthorization ☐Discharge ☐** EXPEDITED** ☐EPSDT

NC SNAP Score___

LOCUS	1 2 3 4 5	**Composite Score**	**LOC Recommendation**
I. Risk of Harm	☐☐☐☐☐		
II. Functional Status	☐☐☐☐☐		
III. Co-Morbidity	☐☐☐☐☐		
IV- a. Recovery Environment. (Support)	☐☐☐☐☐		
IV-b. Recovery Environment. (Stress)	☐☐☐☐☐		
V. Treatment and Recovery History	☐☐☐☐☐		
VI. Engagement	☐☐☐☐☐		
CALOCUS	1 2 3 4 5	**Composite Score**	**LOC Recommendation**
I. Risk of Harm	☐☐☐☐☐		
II. Functional Status	☐☐☐☐☐		
III. Co-Morbidity	☐☐☐☐☐		
IV- a. Recovery Environment. (Support)	☐☐☐☐☐		
IV-b. Recovery Environment. (Stress)	☐☐☐☐☐		
V. Resiliency and Treatment History	☐☐☐☐☐		
VI-a. Acceptance/Engagement (C&Y)	☐☐☐☐☐		
VI-b. Acceptance/Engagement (Parent/PS)	☐☐☐☐☐		

Comments:

ASAM Patient Placement Criteria Adult/Adolescent
(See ASAM criteria for placement considerations)

	I	**II.1/5**	**III.1**	**III.3**	**III.5**	**III.7**	**IV**
I. Withdrawal/Intoxication	☐	☐	☐	☐	☐	☐	☐
II. Medical Complication	☐	☐	☐	☐	☐	☐	☐
III. Behavioral/Emotional Cognitive Complication	☐	☐	☐	☐	☐	☐	☐
IV. Readiness for Change	☐	☐	☐	☐	☐	☐	☐
V. Relapse/Continued use or problem potential	☐	☐	☐	☐	☐	☐	☐
VI. Recovery Environment	☐	☐	☐	☐	☐	☐	☐

Placement Recommendation:

CURRENT(C) and PREVIOUS (P) TREATMENT)

Service	Current / Previous	Comments
Residential	☐ C ☐ P	
Mental Health Outpatient	☐ C ☐ P	
Mental Health Inpatient	☐ C ☐ P	
Substance Abuse Outpatient	☐ C ☐ P	
Detox	☐ C ☐ P	
Substance Abuse Inpatient	☐ C ☐ P	
Other	☐ C ☐ P	

SUBSTANCE USE

Drug of Choice ☐N/A	Age of 1st Use	Route of Usage	Frequency	Amount	Date of Last use
Primary:	Years			Per	
Secondary:	Years			Per	
Tertiary:	Years			Per	
Other:	Years			Per	

MEDICAL: Current Primary Care Physician Name:_____ Signed Release to Primary Care Physician? ☐Yes ☐ No
Medically- ☐ Compliant ☐ Non-compliant ☐Comments:_____

CURRENT MEDICATIONS	Current Regimen	# of months		CURRENT MEDICATIONS	Current Regimen	# of months
mg		☐<1 ☐>1		mg		☐<1 ☐>1
mg		☐<1 ☐>1		mg		☐<1 ☐>1
mg		☐<1 ☐>1		Other:		☐<1 ☐>1
Allergies:						

Reason for Admission, Continued Stay or other comments:

Request for Service

Service Description & Code	Funding Source	Frequency	Duration	Start Date	End Date	Provider/Site Location	UM ACTION	Units Approved
							☐ Approved ☐ Pended ☐ Denied-Pt ☐ Denied-All	
							☐ Approved ☐ Pended ☐ Denied-Pt ☐ Denied-All	
							☐ Approved ☐ Pended ☐ Denied-Pt ☐ Denied-All	

Clinician Signature:	**Requesting Provider:**	**Date:**

Sandhills Center Care Management / Utilization Management Use Only

UM COMMENTS:

Utilization Management Clinical Reviewer: Date:

Sandhills Center Care Management / Utilization Management #: 1-800-241-1073 Fax#: 336-389-6543

**Submission does not automatically constitute authorizations. All treatment is subject to medical necessity determination and based on beneficiary eligibility