Substance Use Disorder Two Business Day Notification and Initial Treatment Plan

Section 1: Patient Information

Patient Name | Date of Birth | MVP Member ID No.

MVP Plan Type
☐ Commercial Plan ☐ Medicaid/Essential Plan

Date of Admission

Diagnosis

Section 2: Provider/Agency Information

Provider/Agency Name | NPI No. | Tax ID No.

Street Address | City | State | Zip Code

Case Manager Name | **Case Manager** Phone

Section 3: Initial Treatment Plan(s)

Initial Detoxification Treatment Plan

Adhere to OASAS-approved detoxification taper/protocol

Medications

Planned Taper Duration

Initial Discharge Plan

☐ To home ☐ Outpatient ☐ Inpatient
☐ Residential ☐ Other *(explain)*

Medical Stabilization Date of Assessment

Medical Stabilization Orders

Initial Rehabilitation Treatment Plan

(Check all that apply)

- ☐ Individual
- ☐ Group
- ☐ Family
- ☐ Skills/medication to reduce urges and/or craving
- ☐ Motivational interviewing to increase internal commitment
- ☐ Coping skills building to improve emotional regulation, self-soothing
- ☐ Facilitate engagement with others—social skills to support recovery
- ☐ Education about, orientation to, and the opportunity to participate in, relevant self-help groups
- ☐ Assessment and referral services for patients and significant others
- ☐ HIV and AIDS education, risk assessment, and supportive counseling and referral

Date of Medical Consultation | Date of Psychiatric Consultation *(as needed)*

Signature *Date*

Please fax this completed form and a copy of the LOCADTR3 Report to **1-855-853-4850**.