



**Medical Concerns:** \_\_\_\_\_  
\_\_\_\_\_

**Allergies:** \_\_\_\_\_  
\_\_\_\_\_

**Medications:** \_\_\_\_\_  
\_\_\_\_\_

**Is client compliant with medications?** \_\_\_ Yes \_\_\_ No

**Diagnosis:** \_\_\_\_\_  
\_\_\_\_\_

**Recent Inpatient/Outpatient History (Names/Dates):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Substance Use (Present or Past):** \_\_\_\_\_  
\_\_\_\_\_

**Current Suicidal/Homicidal Ideations:** \_\_\_ Yes \_\_\_ No

**History Suicide Attempts (if applicable):** \_\_\_\_\_  
\_\_\_\_\_

**Social History:** \_\_\_\_\_  
\_\_\_\_\_

**Legal Concerns:** \_\_\_\_\_  
\_\_\_\_\_

**Form Completed By:** \_\_\_\_\_

**NOTE:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*BOH Staff Only\*\*\***

Appointments Scheduled: \_\_\_\_\_

Medical Necessity \_\_\_ Approved \_\_\_ Denied \_\_\_ (Explain: \_\_\_\_\_)

Medical Necessity Authorized By: \_\_\_\_\_

