

EXTENSION REQUEST FOR WITHDRAWAL MANAGEMENT

KING COUNTY BEHAVIORAL HEALTH RECOVERY DIVISION
 401 5TH Ave, Suite 400, Seattle WA, 98104
 Fax: 206-205-1634

REQUESTING SITE INFORMATION	
Agency Name:	
Name of Contact Person:	
Contact Phone:	
Contact Email:	
CLIENT INFORMATION	
Client Name:	DOB:
King County ID (KCID):	Provider One ID:
Date of Admission:	Last Use:
Number of Extension Days Requested:	<input type="checkbox"/> 1 day <input type="checkbox"/> 2 day <input type="checkbox"/> 3 days <input type="checkbox"/> 4 days

Additional days for stabilization are being requested to support the following situations and/or protocols. To support medical necessity, please submit 1) toxicology screen, 2) CIWA/COWS scores, and 3) clinical description of client's needs including intake form with dates of last use, and any current clinical notes describing severity of symptoms.

<input type="checkbox"/>	Patient has been diagnosed with Alcohol Use Disorder and Sedative, Hypnotic, or Anxiolytic Use Disorder and the primary substances of abuse are alcohol and benzodiazepines.
<input type="checkbox"/>	Patient has been diagnosed with a Stimulant Use Disorder and the primary substance of abuse is Methamphetamine. Additional recovery time is needed. This excludes treatment of substance use psychosis.
<input type="checkbox"/>	Patient has been diagnosed with Opioid Use Disorder and is currently taking Methadone.
<input type="checkbox"/>	Patient has been diagnosed with Opioid Use Disorder and their primary substance of abuse is Fentanyl or Fentanyl use has been detected through a urine analysis.
<input type="checkbox"/>	Patient has been diagnosed with Opioid Use Disorder and has been approved for/agreed to start the medication, Naltrexone (Vivitrol). If requesting more than 7 days, then a documented positive naloxone challenge on day 7.

To be completed by King County BHRD staff:

Authorization Decision and Notification:	
<input type="checkbox"/> Extension Request Approved	
<input type="checkbox"/> Number of Extension Days Approved: _____ days through _____	
<input type="checkbox"/> Authorization decision made by:	
<i>(name + credentials)</i>	<i>(date of decision)</i>
King County Care Coordinator	Date
<hr/>	
<input type="checkbox"/> Extension Request Denied	
<input type="checkbox"/> Denial decision made by:	
<i>(name + credentials)</i>	<i>(date of decision)</i>
Name + Credentials	Date
<hr/>	
Date Referent and Client were notified of Extension Decision: _____	
<input type="checkbox"/> notified via email	<input type="checkbox"/> notified via snail mail