

State of Connecticut Department of Mental Health and Addiction Services

CSAT/OPAT DETOX EXCEPTION REQUEST and RECORD of JUSTIFICATION

DATE: _____

PROGRAM NAME: _____ PROGRAM ID # _____

PROGRAM TELEPHONE #: _____

PROGRAM FAX #: _____

PROGRAM E-MAIL ADDRESS: _____

PATIENT ID # _____

PATIENT AGE: _____

CITY/TOWN OF RESIDENCE _____

SOURCE OF PAYMENT: Indigent SAGA Title 19 SSI
 Commercial Insurance Other

Number of detoxes in this program in past 12 months: _____

Date of last detox in this program, PTA: _____

Did the physician justify this current detox episode and assess the patient for other forms of treatment as required by 42 CFR, Part 8-12 (e) (4)?

YES NO

JUSTIFICATION FOR THIS ADMISSION:

- Pregnant Female Medical condition (e.g. hypotension) has potential to complicate withdrawal
- Patient unwilling to consider methadone maintenance On waiting list for maintenance
- Requires detoxification from both alcohol and heroin Co-occurring psychiatric disorder
- Other: _____

Physician's Name

Physician's Signature

Federal HHS: CSAT/OPAT

Fax: (301) 443-3994

Approved Denied

Signature

Date

Explanation: _____

Note: Programs are to send a copy of each exception request to the State Methadone Authority, fax number (860) 418-6691. Prior authorization by the SMA is not required, at this time, for exceptions to the two detox per year limit in Connecticut.

State of Connecticut
Department of Mental Health and Addiction Services

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A:\CSAT – Detox Exception From rev. 8-31-01/smd