

**KING COUNTY BEHAVIORAL HEALTH ORGANIZATION
ITA Extension Request for Hospitalization**

Client Name:		Birth Date:
Inpatient Facility:		
Date of Admission/Detention:		
Principal Diagnosis:		
Other Diagnoses/Medical Co-Morbidity:		
Extension Request:	First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> Fourth <input type="checkbox"/> Fifth <input type="checkbox"/> Sixth <input type="checkbox"/>	

Current Symptoms/Level of functioning:		
Medication adjustments/effectiveness:		
Support Network Issues/Discharge Plan:		
Number of Extension Days Requested:	days through:	discharge date:

Hospital Reviewer Signature: _____ Date: _____

Send to Crisis Connections 206-461-3247 (Fax)

FOR KING COUNTY BEHAVIORAL HEALTH ORGANIZATION USE ONLY

Number of Extension Days Approved: _____ days through _____

Number of Administrative Days Approved: _____ days through _____

Number of Extension Days Denied: _____ days through _____

Authorizing Signature of KCBHO:

_____ Date: _____

Signature of MD (for children under age 18 and all denials):

_____ Date: _____

Comments: _____
