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 ☐ Second ☐ Third ☐ Fourth ☐ Fifth ☐ Sixth ☐	

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: _____

_____

_____