

INSTRUCTIONS: Please print all information. Fax completed form to (877) 471.6658

PATIENT

Name _____ ID # _____ DOB _____ REFERENCE # _____

PROVIDER Individual and/or Group

Name _____ Tax ID # _____ License # _____ Phone # _____
Address _____ City _____ State _____ ZIP _____ Fax # _____

DSM-IV or ICD-9 DIAGNOSIS numeric + description

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____
current highest past year

MEDICAL CONDITIONS

None Chronic Pain
 Asthma/COPD Dementia
 Cancer Diabetes
 Cardiovascular Problems Obesity
 Other _____

CURRENT RISK ASSESSMENT

Suicidal Ideation Plan Intent Hx of harming self N/A
 Homicidal Ideation Plan Intent Hx of harming others N/A

MEDICATIONS

Medication	Psychotropic	Medical	Prescribing MD	PCP	Psychiatrist	Other
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If affective or psychotic disorder is present and no medications are prescribed, please explain: _____

COORDINATION OF CARE

I have communicated with patient's
 PCP Specialist Psychiatrist Therapist

TREATMENT HISTORY

Inpatient: Within past yr 1 to 3 yrs ago More than 3 yrs ago
 Outpatient: Within past yr 1 to 3 yrs ago More than 3 yrs ago

SYMPTOMS and FUNCTIONAL IMPAIRMENT If present, check degree (✓)

	Mild			Mod.			Severe			On Disability		
	Mild	Mod.	Severe	Mild	Mod.	Severe	Yes	No	Mild	Mod.	Severe	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse/Dependence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Substance Abuse is current or focus of treatment, complete the information below:

Substance of Choice	Amount	Frequency	Date of Last Use	Is patient currently participating in a community-based support group? (Includes AA, NA, etc.)
<input type="checkbox"/> Alcohol	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Marijuana	_____	_____	_____	If Yes, frequency of attendance: _____
<input type="checkbox"/> Heroin	_____	_____	_____	Is there a sponsor? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Opioids	_____	_____	_____	
<input type="checkbox"/> Cocaine <i>list</i>	_____	_____	_____	
<input type="checkbox"/> Methamphetamine	_____	_____	_____	
<input type="checkbox"/> Prescrip. Drugs	_____	_____	_____	
<input type="checkbox"/> Inhalants <i>list</i>	_____	_____	_____	

DESIRED OBSERVABLE OUTCOMES

Patient agrees with treatment goals Yes No

PROVIDER'S CONTINUED TREATMENT PLAN

Modality and CPT Code	Frequency	Anticipated Completion
<input type="checkbox"/> Individual 90804	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Ind. w/Med. Mgmt 90805	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Individual 90806	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Ind. w/ Med. Mgmt. 90807	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Couple/Family 90847	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Group 90853	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Medication Mgmt 90862	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Other _____	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)

TREATMENT PROGRESS

Level of improvement to date Minor Moderate Major
 No progress to date Maintenance tx of chronic condition
of sessions provided to date _____
Start date for new authorization _____

Case Management Referral? Yes No

My signature confirms that I am providing the requested services.

PROVIDER'S SIGNATURE

DATE