OUTPATIENT TREATMENT REPORT

INSTRUCTIONS: Please print all information. Fax completed form to (877) 521-4787 (toll-free).

PATIENT
Name ______ ID # ______ DOB ______

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

MEDICATIONS

Medication	Psycho-tropic	Medical	Prescribing MD	PCP	Psychi-atrist	Other
______	☐	☐	______	☐	☐	☐
______	☐	☐	______	☐	☐	☐
______	☐	☐	______	☐	☐	☐

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* On Disability? ☐ Yes ☐ No

	Mild	Moderate	Severe		Mild	Moderate	Severe		Mild	Moderate	Severe
Anxiety	☐	☐	☐	Hopelessness	☐	☐	☐	Obsessions/Compulsions	☐	☐	☐
Decreased Energy	☐	☐	☐	ADLs	☐	☐	☐	Significant Weight Change	☐	☐	☐
Delusions	☐	☐	☐	Family/Relationships	☐	☐	☐	Panic Attacks	☐	☐	☐
Depressed Mood	☐	☐	☐	Inattention	☐	☐	☐	Sleep Disturbance	☐	☐	☐
Hallucinations	☐	☐	☐	Irritability/Mood instability	☐	☐	☐	Physical Health	☐	☐	☐
Hyperactivity	☐	☐	☐	Impulsivity	☐	☐	☐	Work/School	☐	☐	☐
Substance Abuse/Dependence	☐	☐	☐	☐ In Remission ☐ Active							

(If active or focus of treatment, complete the information below):

Substance of Choice	Amount	Frequency	Date of Last Use
☐ Alcohol	______	______	______
☐ Marijuana	______	______	______
☐ Heroin	______	______	______
☐ Opioids ______	______	______	______
☐ Cocaine *list*	______	______	______
☐ Methamphetamine	______	______	______
☐ Prescr. Drugs ______	______	______	______
☐ Inhalants *list*	______	______	______

Is patient currently participating in a community-based support group? (Includes AA, NA, etc.)
☐ Yes ☐ No
If Yes, frequency of attendance ______
Is there a sponsor?
☐ Yes ☐ No

DESIRED OBSERVABLE OUTCOMES Patient agrees with treatment goals ☐ Yes ☐ No
______

PROVIDER'S CONTINUED TREATMENT PLAN

Modality and CPT Code	Frequency	Anticipated Completion
☐ Individual 90804	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Ind. w/ Med Mgmt 90805	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Individual 90806	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Ind. w/ Med Mgmt 90807	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Couple/Family 90847	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Group 90853	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Medication Mgmt 90862	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Other ______	____ x per ☐ wk ☐ mo ☐ 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 ______

My signature confirms that I am providing the requested services.

______ ______
PROVIDER'S SIGNATURE ***DATE***

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