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 # _____

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
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐

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	☐	☐	☐	☐ Active ☐ In Remission							

If Substance Abuse is current 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 90832	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Individual 90834	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Individual 90833*	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Individual 90836*	____ 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)
☐ Other _____	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)

***MDs or Nurse Practitioners only**

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***