

**Identifying Data**

Patient's Name \_\_\_\_\_  
 Sex: { } Female { } Male  
 Subscriber #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Provider's Name/Credentials: \_\_\_\_\_  
 Clinic Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City State/Zip: \_\_\_\_\_  
 Fax #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Billing Tax ID #: \_\_\_\_\_  
 Date of Intake: \_\_\_\_\_ Total Sessions to date: \_\_\_\_\_  
 Date of last session: \_\_\_\_\_ Referral Source: \_\_\_\_\_

**DSM-IV Diagnosis**

**Axis I:** / / / ./ / / / / / / / / / / / / / /  
**Axis II:** / / / ./ / / / / / / / / / / / / / /  
**Axis III:** \_\_\_\_\_  
**Axis IV:** \_\_\_\_\_  
**Axis V:** Current: \_\_\_\_\_ Highest in last year: \_\_\_\_\_  
 Expected GAF at Discharge: \_\_\_\_\_

**Treatment Plan**

**I. Initial Goals**

(Focal goals for treatment: specific, measurable, timely)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**IV. Treatment Modality & Frequency of Service**

Psychiatric Codes & Treatment Requested	Frequency/Month	# of sessions requested
<input type="checkbox"/> 908 _____	_____	_____
<input type="checkbox"/> 908 _____	_____	_____
Evaluation and Management Codes		
<input type="checkbox"/> 99 _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____

**Additional Clinical Information:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**II. Treatment Provided** (check all that apply)

- Psychiatric Evaluation
- Medication Management
- Individual Psychotherapy
- Other (Specify) \_\_\_\_\_
- Family Therapy
- Group Therapy

**III. Expected Outcome & Prognosis**

- Return to normal functioning
- Expect improvement, anticipate less than normal functioning
- Relieve acute symptoms, return to baseline functioning
- Maintain current status/prevent deterioration

Providers Signature

Date Prepared



Certification Request / Initial Outpatient Behavioral Health Treatment Plan – Confidential

ASSESSMENT

**Previous Treatment** (Check all that apply.)

**Substance Abuse**

None

Outpatient

Inpatient

One prior admission

2 or more prior admissions

Within last 12 months

**Other Psychiatric**

None

Outpatient

Inpatient

One prior admission

2 or more prior admissions

Within last 12 months

**Presenting Problem**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Signs & Symptoms** (Check all that apply. Those not checked will be assumed absent.)

**Depression**

Depressed mood

Decreasing Energy

Hopeless/Helpless

Worthless/Guilt

Appetite (up/down)

Sleep (up/down)

Psychomotor/Retardation/Agitation

**Mania**

Increased Energy

Insomnia

Irritability/Expansive Mood

Grandiosity/Hyperreligiosity

Pressured Speech

Racing Thoughts

Racing thoughts/flight of ideas

**Anxiety**

Generalized

Panic/Phobias

Obsessions/Compulsion

PTSD Symptoms

Somatic Complaints

**Personality Disorder**

Unjustified

Emotional detachment

Oddness & eccentricities

Disregard for law

Recurring self-injuries

Attention Seeking

Sense of entitlement

Avoidant behavior

Dependency

Perfectionism

Passive resistance

Enduring traits of:

**Substance Abuse**

Loss of Control of Dosage

Amnesic Episodes

Legal Problems

Substance Related/ Medical problems

Illicit Drug Use

**Psychosis**

Hallucinations

Delusions

Disorganized Thought Processes/ Loose Association

**Other**

Hyperactivity/ Attention Deficit

Conduct Disorder

Oppositionalism

Concomitant Medical Problem

Dementia

Impulsiveness

Risk Taking Behavior

Separation Problems

Bulimia/Anorexia

\_\_\_\_\_

**Symptoms of current episode have been present for:**

Less than 1 month    1-6 months    7-11 months    12 months or more

**Risk Assessment (check all that apply)**

Suicidality    Not present    Ideation    Plan    Means

Prior Attempt   Date of prior attempt \_\_\_\_\_

Homicidality    Not present    Ideation    Plan    Means

Prior Attempt   Date of prior attempt \_\_\_\_\_

**Other risk behaviors (including high risk sexual activity)** \_\_\_\_\_

**Are there other individuals at risk?**    No    Yes

**Medications: (list all medications)**

\_\_\_\_\_

**Functioning**

**Clinical Global Impression (CGI): Impairment Levels**

Normal/No Impairment    Slight    Mild    Moderate

Severe    Very Severe    Maximal/ Profound

**Check functioning domains that are currently impaired and are treatment targets:**

Marriage/Relationship/Family    Job/School Performance

Friendships/Peer relationships    Disability leave

Financial Situation    Job/School Jeopardy

Physical Health    Hobbies/Interest/Play Activities

Ability to Concentrate    Ability to Control his/her temper

Activities of Daily living (personal hygiene, bathing, etc.)

Eating Habits

Weight loss \_\_\_\_\_ Lbs.    Weight gain \_\_\_\_\_ lbs    Current Weight \_\_\_\_\_ Height \_\_\_\_\_

Sleeping Habits

Difficulty Falling Sleep    Difficulty Staying Asleep    Early Morning Awakening

Sexual Function

Legal Problems

Other: \_\_\_\_\_

**Mental Status**

**Appearance:**    Normal    Disheveled    Abn. Speech    Poor Eye Contact

**Affect:**    Appropriate    Blunted    Labile

Inappropriate    Tearful

**Mood:**    Euthymic    Anxious    Depressed

Irritable    Euphoric

**Sensorium:**    Intact    Impaired

**Memory:**    Intact    Impaired: Intermediate/Short-Term

**Thought Content:**    Unremarkable    Endorses Suicidal/Homicidal Ideation    Delusions

**Thought Process:**    Linear    Non-linear    Hallucinations/Auditory

Flight of ideas    Loose Associations   Visual, Tactile, Olfactory

**Judgement:**    Normal    Impaired

Thank you for completing this form. **Please include any other information you may feel is appropriate on Additional paper.**

**Return form to:**

HIRSP

Medical Affairs

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