Behavioral HealthCare Program Outpatient Treatment Plan

Member Name:	Member ID#:
Member DOB:	Subscriber Name (if other than patient):
Member Address:	Member Phone (home):
Facility/Practice Name (if applicable):	
Provider Name:	Provider Address:
Provider Phone:	

Session Information:

Additional Visits Requested:	Date for Requested Authorization to Start:

Individual Family/Conjoint Group Weekly Every 2 Weeks Monthly

Diagnosis Information (use specific code WITH ALL MODIFIERS):

Axis I: Secondary:	Axis II:
Axis III (current medical condition, **if relevant** to Axis I or II):	
Axis IV:	Current GAF: Highest GAF in past 12 months:

Clinical Status:

PHQ-9 Ratings: Baseline : _____ Date: _____; Score: _____ Date: _____; Score: _____ Date: _____

Score: _____ Date: _____; Score: _____ Date: _____; Score: _____ Date: _____

1. Current extent of alcohol, illicit drug or nicotine use (type and frequency): _____
2. Who is the prescribing and/or monitoring physician? _____ Has he/she been contacted? _____
3. Name and dosage of **ALL** psychotropic medications: _____

_____

4. If prescribing physician is not the PCP, have you contacted the PCP? YES NO When? _____
5. If your patient has refused release of information for collaborative care with either PCP or prescribing physician, have you documented this in your treatment record? _____

Clinical Symptoms: 1-Mild; 2-Moderate; 3-Severe

1 2 3 Anxious	1 2 3 Self Injurious	1 2 3 Suicidal Ideation	Other _____
1 2 3 Depressed	1 2 3 Substance Abuse	1 2 3 Homicidal Ideation	_____
1 2 3 Irritable/Agitated	1 2 3 Sleep Disorder	1 2 3 Obsessive Thoughts	_____
1 2 3 Panic	1 2 3 Weight Gain/Loss	1 2 3 Hallucinations	_____
1 2 3 Physical Aggression	1 2 3 Judgement Impaired	1 2 3 Delusions	

For each goal, please list: Plan & Timeframe

Goal	Plan	Timeframe
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

Anticipated Completion Date of Treatment: _____

Signature of Provider: _____ Date: _____