Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

Outpatient Services Review

Member Name: _____ **ID#:** _____
Date of Birth: _____ **Provider:** _____
Provider Address: _____
Contact Number: _____

Fax completed form to CBHA: (888) 908-7140

Axis I: _____ **Axis II**: _____
_____
_____

Axis III: __Hypertension __Diabetes __Respiratory Prob __ Cancer __Cardiac
__ Obesity __ Pain __ Gastrointestinal __ Other: _____

Axis IV: __Economic __Social __Occupational __Education __Medical
__ Legal __Support

Axis V: First GAF: _____ Current GAF:_____

CGI Severity of Illness: __Normal __Borderline Mentally Ill __Mildly Ill
__Moderately Ill __Markedly Ill __Severely Ill
__Among Most Extremely Ill

CGI Global Improvement: __Very Much Improved __ Much Improved
__Minimally Improved __No Change __ Minimally Worse
__Much Worse __Very Much Worse

Treatment History

How long has patient been in treatment?
__Less than 1 yr __More than 1 yr __More than 2 yrs __3 yrs+

How long has the patient been in treatment with you?
__Less than 1 yr __More than 1 yr __More than 2 yrs __3 yrs+

Is compliance with medical treatment a problem? __Yes __No

How many times has the patient been hospitalized for a psychiatric condition?
__None __One time __two times __three or more times

If hospitalized in the last 12 months, how long ago was the most recent episode?
__0-3 months __3-6 months __6-9 months __9-12 months

Substance Abuse History

Does the patient currently have a substance abuse problem? __Yes __No

Is the patient receiving treatment for the substance abuse problem? __Yes __No

If so, what type of treatment? __ 12-Step group __OP __ IOP __Partial __Detox

Has the patient received treatment in the past for substance abuse? __Yes __No
If so, what type of treatment? __12 Step Group __OP __IOP __Partial __Detox

Focus of Care

What is the focus of current psychotherapy? _____
_____

What assignments are you requiring outside of sessions? _____
_____

Is the patient adhering to assignments? __Yes __No

Risk Factors:

Suicidal Ideations: __None __ Mild __ Moderate __ Severe
Homicidal Ideations: __None __ Mild __ Moderate __ Severe
Binging/Purging: __None __ Mild __ Moderate __ Severe
Psychosis: __None __ Mild __ Moderate __ Severe
Mood Instability: __None __ Mild __ Moderate __ Severe
Impulsivity: __None __ Mild __ Moderate __ Severe
Anxiety: __None __ Mild __ Moderate __ Severe
Substance Abuse: __None __ Mild __ Moderate __ Severe
Hopelessness/Helplessness: __None __ Mild __ Moderate __ Severe
Medical: __None __ Mild __ Moderate __ Severe
ADL's: __None __ Mild __ Moderate __ Severe
Family/Social: __None __ Mild __ Moderate __ Severe
Work/Life: __None __ Mild __ Moderate __ Severe

Medications and Coordination of Care

Does the client have a referral for a medication eval? __Yes __No

Is a psychiatric referral needed? __Yes __No

Is the client currently taking psychotropic drugs? __Yes __No

Who is prescribing? __Psychiatrist __PCP __Other: _____

Type of Medications: __Anti-Depressant __Anti-Anxiety __Anti-Psychotic
__Mood Stabilizer __ Sedative __ Stimulant

Is client compliant with medications? __Yes __No

Have you communicated with the Prescriber? __Yes __No
Have you communicated with the PCP? __Yes __No

Factors Preventing Closure of Treatment

Is a Severe and Persistent Mental Illness or a Dual Diagnosis (mental health and substance abuse diagnosis) issue impacting the ability of the member to recover?
Yes No

List active and severe stressors: _____
_____
_____

Client is resistant to treatment? __Yes __No

Client has a chronic medical illness? __Yes __No

Client is making good progress- Close to goal? __Yes __No

Would a Second Opinion be useful? __Yes __No

What is preventing closure? _____
_____

Prognosis:

__ Discharge this authorization period. No follow up
__ Discharge this authorization period. Return as needed.
__ Active tapering of visit frequency
__ Provide ongoing psychotherapy
__Transition to Self Help Groups
__Other: _____

Projected Discharge Date: Month: ___ Year: _____

Frequency of Sessions: __Twice per week __Weekly __Every Two Weeks
__Every Three Weeks __Monthly __Every 5-6 Weeks
__Every 8-10 Weeks __Quarterly

Number of Visits Requested: _____

Signature: _____ **Date:** _____