

Outpatient Services Review

Member Name: _____ ID#: _____

Date of Birth: _____ Provider: _____

Provider Address: _____

Contact Number: _____

Fax completed form to CBHA: (336) 499-4006

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: _____