

PART 3 – THERAPEUTIC INTERVENTIONS

A. PROPOSED TREATMENT (Check all services for which Authorization is requested)

Modality	Frequency (e.g., 2/wk, 1/mo)	CPT Code
<input type="checkbox"/> Individual		
<input type="checkbox"/> Group		
<input type="checkbox"/> Family		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Conjoint		
<input type="checkbox"/> Other (Specify Code):		

Date first seen for current episode:
 Estimated discharge date:
 Expected number of visits:

B. PSYCHIATRIC MEDICATION

Has patient been evaluated for medication? Yes No
 Does patient follow medication regimen? Yes No

Medication	Dose/Frequency	Start Date
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Comments: (e.g., lab results, prescriber, side effects)

C. OTHER PSYCHIATRIC, MEDICAL OR COMMUNITY SUPPORT SERVICES CLIENT RECEIVES: (Specify e.g., NA/AA, group therapy, supportive housing, treatment for medical problems):

D. EXPECTED TREATMENT OUTCOMES (check all that apply)

- Reduction in symptoms and discharge from active treatment
- Return to highest GAF and discharge from active treatment
- Transfer to self help/other supports and discharge from active treatment
- Ongoing supportive counseling to maintain stabilization of symptoms
- Ongoing medication management to maintain stabilization of symptoms

PART 4 - PRESENTING SYMPTOMS TARGETED SYMPTOMS

Mark only those symptoms that apply based on the past 2 weeks or most recent visit. Indicate if the symptom is a target of treatment. Also check target if symptom is currently controlled by medication.

SOCIAL FUNCTIONING /BEHAVIOR

Mild	Mod	Severe	Target	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Socially isolated
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unstable/intense relationships
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perfectionistic/controlling/rigid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distrustful/suspicious
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nonconforming to laws/norms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Threatening
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assaultive
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tantrums
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self mutilating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsive
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional/defiant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/school inhibition
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agitation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Motor retardation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactive
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disorganized
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

COGNITIVE/MEMORY/ATTENTION

Mild	Mod	Severe	Target	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impaired attention/concentration
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory impairment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concrete thinking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disorientation to: time <input type="checkbox"/> place <input type="checkbox"/> person <input type="checkbox"/> situation <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impaired judgment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of insight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circumstantiality/tangentiality
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flight of ideas/racing thoughts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distorted idiosyncratic thinking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

MOOD/AFFECT DISTURBANCE

Mild	Mod	Severe	Target	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal ideation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Homicidal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depressed mood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elated mood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Labile mood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low esteem/excessive
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness/helplessness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/inappropriate anger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest/anhedonia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

SOMATIC DISTURBANCES

Mild	Mod	Severe	Target	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypersomnia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting/laxative/diuretic
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Body weight change
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

ANXIETY

Mild	Mod	Severe	Target	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoidant behavior
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phobia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions/compulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Somatization
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Generalized anxiety
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Separation anxiety
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

PERCEPTUAL DISTURBANCE

Mild	Mod	Severe	Target	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delusions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ideas of reference
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flashbacks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depersonalization/dissociation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

SUBSTANCE USE

Mild	Mod	Severe	Target	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cont. use in spite of knowledge of effects
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to control/decrease use
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent desire for substance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tolerance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Last date of substance use:

PART 5 - ADDITIONAL INFORMATION

For first reviews, briefly state additional information which may help clarify the need for this outpatient treatment, including frequency of targeted behaviors and, where applicable, onset of specific symptoms. For subsequent reviews, briefly state what progress has been made. If no progress, indicate reasons and whether treatment plan is being revised to address targeted symptoms.

Treatment plan discussed with patient, guardian or other legal representative (if applicable), or parent of a minor Yes No

Treatment coordinated with primary care physician Yes No Not applicable

Are additional health services required? Yes No Referred to:

Date:

STEVEN B. LARSEN
Insurance Commissioner