

<u>Carrier Information</u> Name: Address: Phone:	State of Maryland Uniform Treatment Plan Form (For Purposes of Treatment Authorization) <input type="checkbox"/> Initial Plan <input type="checkbox"/> Continuing Report Beginning date for current authorization request month/date/year
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Patient First Name	Membership Number	Group Number	Patient Date of Birth MO DAY YR	Relationship to insured
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Clinician/Provider Name Credentials (Lic/Cert#) Address Phone I.D. (If applicable) Fax	Supervisor (If applicable) Phone Address Clinician Signature Date _____
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PART 1 – PREVIOUS TREATMENT PAST TWO YEARS (COMPLETE FOR INITIAL PLAN ONLY)

<table style="width:100%;"> <tr> <td></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> <td style="text-align: center;">Unknown</td> </tr> <tr> <td>Outpatient</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Partial Hospital</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Residential Tx Center</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sub Abuse Intensive Outpatient</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other:</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> Medical Hx:		Yes	No	Unknown	Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Partial Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Residential Tx Center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sub Abuse Intensive Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Medications (list if known, include name and dose): Compliance: Yes <input type="checkbox"/> No <input type="checkbox"/> Side Effects: Yes <input type="checkbox"/> No <input type="checkbox"/> Comments: Allergies:
	Yes	No	Unknown																						
Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						
Partial Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						
Residential Tx Center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						
Sub Abuse Intensive Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						

PART 2 – CURRENT DIAGNOSIS/ASSESSMENT

DSM-IV DIAGNOSIS Axis I: Axis II: Axis III: Axis IV: Axis V: Current Highest in last year (Document specific GAF score – not range)	FUNCTIONAL ASSESSMENT Category Illness-related Impairment None Mild Moderate Severe Family Relations <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Job/School <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Financial <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physical Health <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Friends/Social <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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RISK ASSESSMENT: Suicidality: Ideation Plan Prior attempts (if known) Other Risk Behavior (e.g., dangerousness to others, self mutilation, etc.) Comments:

OTHER ASSESSMENT INFO (e.g., psychological testing, type and amount of drug(s) of abuse, specific weight gain/loss)

RISK OF RELAPSE INTO CHRONIC/ACUTE SYMPTOMS: High Moderate Low Comments:

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