



OUTPATIENT TREATMENT REPORT

PATIENT Name: _____

ID # _____ DOB: _____

PROVIDER:

Individual and/or Group

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

COORDINATION of CARE:

☎ I have communicated with patient's PCP or specialist: Yes No N/A

☎ I have communicated with patient's psychiatrist or therapist: Yes No N/A

ICD-9* DIAGNOSIS numeric + description (*DSM-IV codes typically correspond to ICD-9 codes) :

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V (current) _____ (highest past year)

PSYCHOTROPIC MEDICATIONS: Prescribed by: PCP Psychiatrist APRN

1. _____

2. _____

3. _____

If affective or psychotic disorder is present and no medications are prescribed, please explain: _____

RISK ASSESSMENT:

Suicidal: Ideation Planned Imminent Intent History of self-harming behavior

Homicidal: Ideation Planned Imminent Intent History of behavior harming others

TREATMENT HISTORY (all prior behavioral treatment) :

Inpatient: Within past year 1 to 3 yrs ago More than 3 years ago

Outpatient: Within past year 1 to 3 yrs ago More than 3 years ago

SYMPTOMS - if present, check degree (✓)

	Mild	Mod.	Severe		Mild	Mod.	Severe
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Mood Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions/Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FUNCTIONAL IMPAIRMENT

ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family/Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance of Abuse:	<input type="checkbox"/> ETOH	<input type="checkbox"/> Rx Drug	<input type="checkbox"/> Other: _____

DEFINITION OF SUCCESSFUL TREATMENT

Desired observable outcomes #1. _____

Desired observable outcomes #2. _____

LEVEL of IMPROVEMENT to DATE: # Sessions provided to date: _____

Minor Moderate Major No progress to date Maintenance tx of chronic condition

Start date for new auth (cannot be more than 30 days from submission) _____

PROVIDER'S CONTINUED TREATMENT PLAN (requested services):

MODALITIES	FREQUENCY	ANTICIPATED COMPLETION
<input type="checkbox"/> Individual	<input type="checkbox"/> weekly	<input type="checkbox"/> less than 1 month
<input type="checkbox"/> Family/Couple	<input type="checkbox"/> twice per month	<input type="checkbox"/> 1 to 2 months
<input type="checkbox"/> Group	<input type="checkbox"/> monthly	<input type="checkbox"/> 2 to 4 months
<input type="checkbox"/> Medication Management	<input type="checkbox"/> less than monthly	<input type="checkbox"/> more than 4 months

Provider Signature

Date

My signature confirms that I am providing the requested services

FAX to: 720-748-5821

Anthem UM Services, Inc., Behavioral Health UM Dept, 700 Broadway, Mail Stop CO 0106-0642, Denver, CO 80273

☎ 1-800-424-4014 (CO)

☎ 1-866-621-0043 (NV)