



One Monarch Place · Suite 1500
 Springfield, MA 01144-1500
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 800-842-4464
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OUTPATIENT MH/SA TREATMENT REQUEST FORM (PAGE 1 OF 2)

FOR SESSIONS BEYOND 20 VISITS YEAR TO DATE, YOU MUST SUBMIT PAGES 1 AND 2.

*Date _____
 *Patient Name _____
 *HNE ID# _____
 *Date of Birth _____
 *Gender Male Female ***required**

*Therapist Name _____
 *HNE ID# _____
 *Agency (if applicable) _____
 *Therapist Phone# _____
 *Billing Office Phone# _____
 *Are you available for referrals? Yes No ***required**

CURRENT RISK INDICATORS (check all that apply)

- | | Low | Moderate | Severe |
|---|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Assaultive/aggressive behavior | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Impulsive behavior | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Suicidal/Homicidal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Self-mutilation/cutting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Current family violence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Caring for ill family member | | | |
| <input type="checkbox"/> Prior psychiatric inpatient stay | | | |
| <input type="checkbox"/> Patient coping w/significant loss (job, relationship, etc) | | | |

Please specify _____

- Prior detox admission
- Other current symptoms/disruptions in patient's functioning
- Please describe _____

DSM IV DIAGNOSES

Axis I/Axis II _____
 Axis III _____
 Axis IV _____
 Current GAF (0-100) _____
 Highest in past Year _____
 Highest GAF _____

- Is treatment mandated by a third party? Yes No
- Is there is a substance abuse problem? Yes No
- (check all that apply)

- AA NA Sponsor Unable to maintain abstinence
- Current Treatment Goals and Relevant Clinical Information

TREATMENT STATUS

(Please rate the patient's response to treatment since last review or since start of treatment if this is first report)

| Behavioral symptoms that are focus of treatment | Much Worse | Slightly Worse | No Changes | Slight Improvement | Major Improvement |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Behavioral symptoms that are focus of treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ability to perform work/school/household tasks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

COORDINATION OF CARE

Are Psychotropic meds being prescribed? Yes No

If yes, prescribed by: MD RN, CS/NP PCP

Prescriber _____

Medication compliant Yes No Patient refuses

Has there been communication with prescriber? Yes No

Has there been communication with PCP?

Yes No No PCP Patient refuses

If yes, date _____

REQUEST FOR SESSIONS

I request _____ sessions over the next _____ month(s) starting on _____.

Requested frequency of sessions _____

Individual

Family

Couple

Group - Attach description for review & approval

Member in treatment with provider since _____

Number of sessions used this calendar year _____

When do you anticipate reducing the frequency? _____



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*Therapist Name _____

****required***

REASONS TO REQUEST ADDITIONAL VISITS

(check all that apply)

- 1. Perpetrator of reportable physical, sexual, or psychological abuse or neglect
- Currently at high risk of hospitalization

Please describe _____

- 2. An unexpected current catastrophic event precipitated a change in the patient's level of functioning.

Please describe _____

- 3. A significant medical problem increases the potential for psychiatric deterioration or results in decreased functioning.

Please describe _____

- 4. An addicted patient is currently unable to maintain abstinence. Attending AA NA

Please describe _____

- 5. Existence of one of the following criteria, regardless of diagnosis:
 - Victim or key member of household where reportable abuse, neglect, or severe assault has occurred
 - History of repeated or long term psychiatric hospitalization or alternative

Please describe _____

- 6. Current existence of one or more of the following combinations of diagnosis and behavior.
 - Substance abuse combined with a diagnosis of schizophrenic disorder or major affective disorder
 - Need for frequent adjustment or close monitoring of psychotropic or other medications combined with a diagnosis of schizophrenic disorder, major affective disorder, or chronic minor atypical affective disorder.

Please describe _____

- 7. What remains to be completed? Please elaborate here with a clinical note or attach a letter.

Please add any additional information in support of this request.

