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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 _____

*Sex Male Female

*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 specify _____
(job, relationship, etc) | | | |
| <input type="checkbox"/> Prior detox admission | | | |
| <input type="checkbox"/> 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: ____

Therapist Name _____

HNE ID # _____

Agency (if applicable) _____

Therapist Phone # _____

Are you available for referrals? Yes No

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 If yes, date: _____

REQUEST FOR SESSIONS

I request: _____ sessions over next: _____ month 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: _____

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



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OUTPATIENT MH/SA TREATMENT REQUEST FORM (PAGE 2 OF 2)

PAGES 1 & 2 ARE REQUIRED FOR REQUESTS OF SESSIONS BEYOND 20:

Patient: _____

HNE ID#: _____

Therapist Name: _____

REASONS TO REQUEST AN EXTENSION OF BENEFITS (CHECK AT LEAST ONE)

1. Current existence of qualifying DSM IV diagnosis with one or more of the following:

- 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: _____

