

# OUTPATIENT TREATMENT REPORT



**INSTRUCTIONS: Please print all information. Fax completed form to 888-479-6431 (NY).**

**PATIENT**

Name \_\_\_\_\_ ID # \_\_\_\_\_ DOB \_\_\_\_\_

**PROVIDER Individual and/or Group**

Name \_\_\_\_\_ Tax ID # \_\_\_\_\_ License # \_\_\_\_\_ Phone # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Fax # \_\_\_\_\_

**DSM-IV or ICD-9 DIAGNOSIS numeric + description**

Axis I \_\_\_\_\_  
 Axis II \_\_\_\_\_  
 Axis III \_\_\_\_\_  
 Axis IV \_\_\_\_\_  
 Axis V \_\_\_\_\_  
*current highest past year*

**MEDICAL CONDITIONS**

None  Chronic Pain  
 Asthma/COPD  Dementia  
 Cancer  Diabetes  
 Cardiovascular Problems  Obesity  
 Other \_\_\_\_\_

**CURRENT RISK ASSESSMENT**

Suicidal  Ideation  Plan  Intent  Hx of harming self  N/A  
 Homicidal  Ideation  Plan  Intent  Hx of harming others  N/A

**MEDICATIONS**

Medication	Psychotropic	Medical	Prescribing MD	PCP	Psychiatrist	Other
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**COORDINATION OF CARE**

I have communicated with patient's  
 PCP  Specialist  Psychiatrist  Therapist

**TREATMENT HISTORY**

Inpatient:  Within past yr  1 to 3 yrs ago  More than 3 yrs ago  
 Outpatient:  Within past yr  1 to 3 yrs ago  More than 3 yrs ago

**SYMPTOMS and FUNCTIONAL IMPAIRMENT** *If present, check degree (✓)*

	On Disability				On Disability		
	Mild	Mod.	Severe		Mild	Mod.	Severe
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family/Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Mood instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse/Dependence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Active <input type="checkbox"/> In Remission			

*If Substance Abuse is current or focus of treatment, complete the information below:*

Substance of Choice	Amount	Frequency	Date of Last Use
<input type="checkbox"/> Alcohol	_____	_____	_____
<input type="checkbox"/> Marijuana	_____	_____	_____
<input type="checkbox"/> Heroin	_____	_____	_____
<input type="checkbox"/> Opioids	_____	_____	_____
<input type="checkbox"/> Cocaine <i>list</i>	_____	_____	_____
<input type="checkbox"/> Methamphetamine	_____	_____	_____
<input type="checkbox"/> Prescrip. Drugs	_____	_____	_____
<input type="checkbox"/> Inhalants <i>list</i>	_____	_____	_____

Is patient currently participating in a community-based support group? (Includes AA, NA, etc.)  
 Yes  No  
 If Yes, frequency of attendance: \_\_\_\_\_  
 Is there a sponsor?  
 Yes  No

**DESIRED OBSERVABLE OUTCOMES**

Patient agrees with treatment goals  Yes  No

**PROVIDER'S CONTINUED TREATMENT PLAN**

Modality and CPT Code	Frequency	Anticipated Completion
<input type="checkbox"/> Individual 90804	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Ind. w/Med Mgmt 90805	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Individual 90806	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Ind. w/ Med. Mgmt. 90807	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Couple/Family 90847	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Group 90853	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Medication Mgmt 90862	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)
<input type="checkbox"/> Other _____	____ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr	____ mo(s)

**TREATMENT PROGRESS**

Level of improvement to date  Minor  Moderate  Major  
 No progress to date  Maintenance tx of chronic condition  
 # of sessions provided to date \_\_\_\_\_  
 Start date for new authorization \_\_\_\_\_

My signature confirms that I am providing the requested services.

\_\_\_\_\_  
**PROVIDER'S SIGNATURE**

\_\_\_\_\_  
**DATE**

**FAX to: 888-479-6431 (NY)**

**Anthem UM Services, PO BOX 2099, North Haven, CT 06473**

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