Mental Health Outpatient Treatment Report Form

INSTRUCTIONS

1. Complete all sections entirely

2. Fax the form to 888-240-4609 / Georgia Families 360º members 888-375-5070

3. You will receive a confirmation number by fax

4. If you have any questions or need assistance with this form, call Provider Services at 1-800-454-3730

FILL OUT COMPLETELY TO AVOID DELAYS

IDENTIFYING DATA		
Patient's name:		
Medicaid ID:		Date of birth:
Patient's address:		
City, State:		ZIP code:
PROVIDER INFORMATION		
Provider name:		
Tax ID:	Phone:	Fax:
PCP name:		PCP NPI:
Name of other behavioral health providers:		
DSM-IV TR Diagnosis		
AXIS I:	AXIS II:	AXIS III:
AXIS IV:	AXIS V CURRENT:	HIGHEST IN PAST YEAR:

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Patient name: _____

CURRENT CLINICAL INFORMATION

Symptoms/Problems	Mild	Moderate	Severe	Acute	Chronic			Mild	Moderate Severe Acute	Chronic
Anxiety disorders							**Psychotic disorders**			
■ Obsessions/compulsions							■ Delusions/paranoia			
■ Generalized anxiety							■ Self-care issues			
■ Panic attacks							■ Hallucinations			
■ Phobias							■ Disorganized thought process			
■ Somatic complaints							■ Loose associations			
■ PTSD symptoms							**Substance abuse**			
Depression							■ Loss of control of dosage			
■ Impaired concentration							■ Amnesic episodes			
■ Impaired memory							■ Legal problems			
■ Psychomotor retardation							■ Alcohol abuse			
■ Sexual issues							■ Opiate abuse			
■ Appetite disturbance							■ Prescription medication abuse			
■ Irritability							■ Polysubstance abuse			
■ Agitation							**Personality disorder**			
■ Sleep disturbance							■ Oddness/eccentricities			
■ Hopelessness/helplessness							■ Oppositional			
Mania							■ Disregard for law			
■ Insomnia							■ Recurring self-injuries			
■ Grandiosity							■ Sense of entitlement			
■ Pressured speech							■ Passive aggressive			
■ Racing thoughts/flight of ideas							■ Dependency			
■ Poor judgment/ impulsiveness							■ Enduring traits of:			

Medications (optional for nonphysicians)

Current medications (indicate changes since last report)	Dosage	Frequency

Patient name: _____

CURRENT RISK FACTORS:

SUICIDE: ❑ None ❑ Ideation ❑ Intent without means ❑ Intent with means ❑ Contracted not to harm self

HOMICIDE: ❑ None ❑ Ideation ❑ Intent without means ❑ Intent with means ❑ Contracted not to harm others

PHYSICAL OR SEXUAL ABUSE OR CHILD/ELDER NEGLECT: ❑ Yes ❑ No

- If "YES" patient is: ❑ Victim ❑ Perpetrator ❑ Both ❑ Neither, but abuse exists in family
- Abuse or neglect involves a child or elder: ❑ Yes ❑ No
- Abuse has been legally reported: ❑ Yes ❑ No

SYMPTOMS THAT ARE THE FOCUS OF CURRENT TREATMENT
PROGRESS SINCE LAST REVIEW
FUNCTIONAL IMPAIRMENTS OR SUPPORTS
Family/interpersonal relationships:
JOB/SCHOOL
HOUSING
CO-OCCURRING MEDICAL/PHYSICAL ILLNESS
FAMILY HISTORY OF MENTAL ILLNESS

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Patient name: _____

PATIENT'S TREATMENT HISTORY INCLUDING ALL LEVELS OF CARE

Level of care	Number of distinct episodes/ sessions of	Date of last episode/session		Level of care	Number of distinct episodes/ sessions of	Date of last episode/session
Outpatient psych				PHP		
Outpatient – substance abuse				Inpatient – psych RTC		
IOP				Inpatient – substance abuse		

TREATMENT GOALS

1. _____
2. _____
3. _____

OBJECTIVE OUTCOME CRITERIA BY WHICH GOAL ACHIEVEMENT IS MEASURED

1. _____
2. _____
3. _____

DISCHARGE PLAN AND ESTIMATED DISCHARGE DATE

EXPECTED OUTCOME AND PROGNOSIS

- ❑ Return to normal functioning
- ❑ Expect improvement, anticipate less than normal functioning
- ❑ Relieve acute symptoms, return to baseline functioning
- ❑ Maintain current status, prevent deterioration

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Patient name: _____

Risk history: Explain any significant history of suicidal, homicidal, impulse control or any behavior that may impact the patient's level of functioning:

Requested authorization			
Procedure code	Number of units	Frequency	Units approved
Procedure code	Number of units	Frequency	Units approved
Procedure code	Number of units	Frequency	Units approved
Procedure code	Number of units	Frequency	Units approved
Procedure code	Number of units	Frequency	Units approved

Provider's signature: _____
Date: _____

Disclaimer: Authorization indicates that Amerigroup determined medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.