Outpatient Treatment Report FORM C

AMERIGROUP **Community Care**
TELEPHONE: 1-800-454-3730 FAX: 1-800-505-1193

AMERIGROUP Community Care

FILL OUT COMPLETELY TO AVOID DELAYS

IDENTIFYING DATA

PATIENT'S NAME: **MEDICAID #:** **DOB:**

PATIENT'S ADDRESS: **STATE:** **ZIP CODE:**

PROVIDER INFORMATION

PROVIDER NAME: **TAX ID NUMBER:**

PHONE #: **FAX #:**

PCP NAME: **NAME OF OTHER BEHAVIORAL HEALTH PROVIDER(S):**

PCP NPI #:

DSM-IV TR DIAGNOSIS

AXIS I: **AXIS II:** **AXIS III:**

AXIS IV: **AXIS V CURRENT:** **HIGHEST IN PAST YEAR:**

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:					

PATIENT NAME:

MEDICATIONS *(optional for non-physicians)*

CURRENT MEDICATIONS *(indicate changes since last report)*	**DOSAGE**	**FREQUENCY**

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 ILLNESSES:

FAMILY HISTORY OF MENTAL ILLNESS:

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

RISK HISTORY:

Explain any significant history of suicidal, homicidal, impulse control or any behavior that may impact 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:

❑ Approved – Auth #:

PROVIDER'S SIGNATURE: **DATE:**

Disclaimer: Authorization indicates that AMERIGROUP determined that 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.