Community **HealthFirst**™
Medicare Advantage Plans

**Mental Health Outpatient Treatment Review Form** Fax ##206-652-7067 Service #800-336-5231 ext. 7496

**Member:** _____ **Provider Name:** _____ **Provider Telephone:** _____
**Member DOB:** _____ **Provider Group/Clinic:** _____ **Provider Fax:** _____
**Member ID:**_____ **Service Address:** _____ **City/State/Zip:** _____
**Provider ID/NPI:** _____ **Tax ID#** _____

## Mental Health/Substance Abuse History

| ☐**Yes** ☐**No** Previous mental health treatment inpatient/outpatient if yes: | |
|---|---|
| **Level of care:** | **Dates Tx:** |
| **Level of care:** | **Dates Tx:** |
| **Level of care:** | **Dates Tx:** |

☐**Yes** ☐**No** Drug/Alcohol Use (For Past 12 Months) If **YES** complete the following:

| **Substance** | **Amount** | **Frequency** | **Age Began** | **Last Used** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## Clinical Assessment

**Current Signs/Symptoms**

| | | | | | |
|---|---|---|---|---|---|
| ☐**Yes** ☐**No** | Generalized Anxiety | ☐**Yes** ☐**No** | Pressured Speech | ☐**Yes** ☐**No** | Loose Associations |
| ☐**Yes** ☐**No** | Depressed Mood | ☐**Yes** ☐**No** | Weight Loss/Gain | ☐**Yes** ☐**No** | Psychomotor Retardation |
| ☐**Yes** ☐**No** | Appetite Disturbance | ☐**Yes** ☐**No** | Panic Attacks | ☐**Yes** ☐**No** | Concentration/Attention Problems |
| ☐**Yes** ☐**No** | Sleep Disturbance | ☐**Yes** ☐**No** | Phobias | ☐**Yes** ☐**No** | Impulse Control Problems |
| ☐**Yes** ☐**No** | Low Energy | ☐**Yes** ☐**No** | Obsessions/Compulsions | ☐**Yes** ☐**No** | Conduct Problems |
| ☐**Yes** ☐**No** | Agitation | ☐**Yes** ☐**No** | Circumstantial/Tangential | ☐**Yes** ☐**No** | Oppositional Behaviors |
| ☐**Yes** ☐**No** | Labile | ☐**Yes** ☐**No** | Sexual Dysfunction | ☐**Yes** ☐**No** | Acute Stress Disorder |
| ☐**Yes** ☐**No** | Irritability | ☐**Yes** ☐**No** | Paranoid Ideation | ☐**Yes** ☐**No** | Other |

**Mental Status**

| | | | | | |
|---|---|---|---|---|---|
| ☐**Yes** ☐**No** | Oriented x3 | ☐**Yes** ☐**No** | Impaired Memory | ☐**Yes** ☐**No** | Delusions |
| ☐**Yes** ☐**No** | Impaired Judgment | ☐**Yes** ☐**No** | Other Cognitive Impairment | ☐**Yes** ☐**No** | Hallucinations |

**Risk Assessment**

| | | | | | |
|---|---|---|---|---|---|
| ☐**Yes** ☐**No** | SUICIDAL RISK: | ☐**Yes** ☐**No** | HOMICIDAL RISK: | ☐**Yes** ☐**No** | ABUSE RISK: |
| ☐**Yes** ☐**No** | Ideation | ☐**Yes** ☐**No** | Ideation | ☐**Yes** ☐**No** | Verbal |
| ☐**Yes** ☐**No** | Intent | ☐**Yes** ☐**No** | Intent | ☐**Yes** ☐**No** | Emotional |
| ☐**Yes** ☐**No** | Plan | ☐**Yes** ☐**No** | Plan | ☐**Yes** ☐**No** | Physical |
| ☐**Yes** ☐**No** | Means | ☐**Yes** ☐**No** | Means | ☐**Yes** ☐**No** | Sexual |
| ☐**Yes** ☐**No** | Attempt | ☐**Yes** ☐**No** | Attempt | | |

| **Medication Name/Dosage/Frequency:** | **Rx by: Psychiatrist** ☐ **PCP** ☐ | **Not applicable:**☐ |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |

**Diagnosis** (please include mental health diagnosis in Axis I if applicable)

**Axis I:**
**Axis II:**
**Axis III:**
**Axis IV:**
**Axis V: Current GAF=** **Past year GAF=**

## Treatment Plan

**Member: _____ ID#_____**

| |
|---|
| **GOAL #** |
| **Progress/Lack of Progress on Goal:** |
| |
| **Goal Status:** __ Accomplished & Removed__ Continue__ Additional Progress Needed __ Revised –See New goal/objective |
| |
| **GOAL #** |
| **Progress/Lack of Progress on Goal:** |
| |
| **Goal Status:** __ Accomplished & Removed__ Continue__ Additional Progress Needed __ Revised –See New goal/objective |
| **GOAL #** |
| **Progress/Lack of Progress on Goal:** |
| |
| **Goal Status:** __ Accomplished & Removed__ Continue__ Additional Progress Needed __ Revised –See New goal/objective |

**Discharge criteria/Plan:**

**Number of sessions required to conclude this treatment episode of care:_____**

**Treatment Request**

**Date of first visit for this episode of care: _____** **Number of sessions to date:_____**

**Requested Start Date for this registration: _____**

**Please indicate type(s) of service requested and frequency:**

☐**Diagnostic Evaluation 90791/90792 (medical)**
☐Wkly ☐Mthly ☐Qrtly ☐Other

☐**Individual Psychotherapy (45min) 90834**
☐Wkly ☐Mthly ☐Qrtly ☐Other

☐**Medication Management 99213**
☐Wkly ☐Mthly ☐Qrtly ☐Other

☐**Family Psychotherapy (60-90min) 90847**
☐Wkly ☐Mthly ☐Qrtly ☐Other

☐**Individual Psychotherapy (30min) 90832**
☐Wkly ☐Mthly ☐Qrtly ☐Other

☐**Other Code/s:_____**
☐Wkly ☐Mthly ☐Qrtly ☐Other

Clinician Signature: _____ Date: _____