Community **HealthFirst**™
Medicare Advantage Plans

Chemical Dependency Outpatient Treatment Review Form Fax #206-652-7067 Service #800-942-0247

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

Substance Abuse History (including alcohol, drugs, and prescription medication)	
☐**Yes** ☐**No** Previous substance abuse treatment inpatient/outpatient If yes:	
Level of care:	**Dates Tx:**
Level of care:	**Dates Tx:**
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☐**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

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Goal Status: Accomplished & Removed Continue Additional Progress Needed Revised –See New goal/objective

Attended AA/NA? ☐**YES** ☐**NO** **Linked to a Sponsor** ☐**Yes** ☐**No**

TOXICOLOGY

Substance	Amount	Frequency	Age Began	Last Used

Toxicology Substance: ALC: Alcohol; AMP: Amphetamine: BAR: Barbiturates: BEZ: Benzodiazepine: COC: Cocaine; MET: Methadone; Opiate OPI: Opiates; PCP; PM: Prescription Medication: SUB: Suboxone: THC: THC

Discharge criteria/Plan:

Number of sessions required to conclude this treatment episode ofcare:_____

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**
☐Wkly ☐Mthly ☐Qrtly ☐Other

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

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

☐**Group Psychotherapy (60-90min) 90853**
☐Wkly ☐Mthly ☐Qrtly ☐Other

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

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

Clinician Signature:_____ Date: _____