Certification Request/Initial Outpatient Behavioral Health Treatment Plan– Confidential

Identifying Data

Patient's Name ______________________

Sex: { } ____ Female { } ____ Male

Subscriber #: ____________ Date of Birth: ____________

Provider' s Name/Credentials: ____________

Clinic Name: ____________

Address: ____________

City State/Zip: ____________

Fax #: ____________ Phone #: ____________

Billing Tax ID #: ____________

Date of Intake: ____________ Total Sessions to date: ____________

Date of last session: Referral Source:

DSM-IV Diagnosis

Axis I: / / / /./ / /   / / / /./ / /   / / / /./ / /

Axis II: / / / /./ / /   / / / /./ / /   / / / /./ / /

Axis III: ____________

Axis IV: ____________

Axis V: Current: ____________ Highest in last year: ____________

Expected GAF at Discharge:

Treatment Plan

I. Initial Goals

(Focal goals for treatment: specific, measurable, timely)

II. Treatment Provided (check all that apply)

- ☐ Psychiatric Evaluation
- ☐ Medication Management
- ☐ Individual Psychotherapy
- ☐ Other (Specify) ____________________________________
- ☐ Family Therapy
- ☐ Group Therapy

III. Expected Outcome & Prognosis

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

IV. Treatment Modality & Frequency of Service

Psychiatric Codes & Treatment Requested	Frequency/Month	# of sessions requested
☐ 908 ______ ______		
☐ 908 ______ ______		

Evaluation and Management Codes

☐ 99 ______ ______		

☐ Other ____________

Additional Clinical Information:

Providers Signature Date Prepared

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ASSESSMENT

Previous Treatment (Check all that apply.)

Substance Abuse
- ☐ None
- ☐ Outpatient
- ☐ Inpatient
  - ☐ One prior admission
  - ☐ 2 or more prior admissions
  - ☐ Within last 12 months

Other Psychiatric
- ☐ None
- ☐ Outpatient
- ☐ Inpatient
- ☐ One prior admission
  - ☐ 2 or more prior admissions
  - ☐ Within last 12 months

Presenting Problem

____
____
____
____
____

Current Signs & Symptoms (Check all that apply. Those not checked will be assumed absent).

Depression
- ☐ Depressed mood
- ☐ Decreasing Energy
- ☐ Hopeless/Helpless
- ☐ Worthless/Guilt
- ☐ Appetite (up/down)
- ☐ Sleep (up/down)
- ☐ Psychomotor/Retardation/ Agitation

Mania
- ☐ Increased Energy
- ☐ Insomnia
- ☐ Irritability/Expansive Mood
- ☐ Grandiosity/Hyperreligiosity
- ☐ Pressured Speech
- ☐ Racing Thoughts
- ☐ Racing thoughts/flight of ideas

Anxiety
- ☐ Generalized
- ☐ Panic/Phobias
- ☐ Obsessions/Compulsion
- ☐ PTSD Symptoms
- ☐ Somatic Complaints

Personality Disorder
- ☐ Unjustified
- ☐ Emotional detachment
- ☐ Oddness & eccentricities
- ☐ Disregard for law
- ☐ Recurring self-injuries
- ☐ Attention Seeking
- ☐ Sense of entitlement
- ☐ Avoidant behavior
- ☐ Dependency
- ☐ Perfectionism
- ☐ Passive resistance
- ☐ Enduring traits of:

Substance Abuse
- ☐ Loss of Control of Dosage
- ☐ Amnesic Episodes
- ☐ Legal Problems
- ☐ Substance Related/ Medical problems
- ☐ Illicit Drug Use

Psychosis
- ☐ Hallucinations
- ☐ Delusions
- ☐ Disorganized Thought Processes/ Loose Association

Other
- ☐ Hyperactivity/ Attention Deficit
- ☐ Conduct Disorder
- ☐ Oppositionalism
- ☐ Concomitant Medical Problem
- ☐ Dementia
- ☐ Impulsiveness
- ☐ Risk Taking Behavior
- ☐ Separation Problems
- ☐ Bulimia/Anorexia
- ☐ ___________________

Symptoms of current episode have been present for:

☐ Less than 1 month ☐ 1-6 months ☐ 7-11 months ☐ 12 months or more

Risk Assessment (check all that apply)

Suicidiality ☐ Not present ☐ Ideation ☐ Plan ☐ Means
☐ Prior Attempt Date of prior attempt ________

Homicidality ☐ Not present ☐ Ideation ☐ Plan ☐ Means
☐ Prior Attempt Date of prior attempt ________

Other risk behaviors (including high risk sexual activity) ______________________

Are there other individuals at risk? ☐ **No** ☐ **Yes**

Medications: (list all medications)

Functioning

Clinical Global Impression (CGI): Impairment Levels

☐ Normal/No Impairment ☐ Slight ☐ Mild ☐ Moderate
☐ Severe ☐ Very Severe ☐ Maximal/ Profound

Check functioning domains that are currently impaired and are treatment targets:
- ☐ Marriage/Relationship/Family
- ☐ Friendships/Peer relationships
- ☐ Financial Situation
- ☐ Physical Health
- ☐ Ability to Concentrate
- ☐ Activities of Daily living (personal hygiene, bathing, etc.)
- ☐ Eating Habits
  - ☐ Weight loss _____ Lbs. ☐ Weight gain ___ lbs ☐ Current Weight ____ Height _____
- ☐ Sleeping Habits
  - ☐ Difficulty Falling Sleep ☐ Difficulty Staying Asleep ☐ Early Morning Awakening
- ☐ Sexual Function
- ☐ Legal Problems
- ☐ Other: ____
- ☐ Job/School Performance
  - ☐ Disability leave
  - ☐ Job/School Jeopardy
- ☐ Hobbies/Interest/Play Activities
- ☐ Ability to Control his/her temper

Mental Status

Appearance:	☐ Normal	☐ Disheveled	☐ Abn. Speech	☐ Poor Eye Contact
Affect:	☐ Appropriate	☐ Blunted	☐ Labile	
	☐ Inappropriate	☐ Tearful		
Mood:	☐ Euthymic	☐ Anxious	☐ Depressed	
	☐ Irritable	☐ Euphoric		
Sensorium:	☐ Intact	☐ Impaired		
Memory:	☐ Intact	☐ Impaired: Intermediate/Short-Term		
Thought Content:	☐ Unremarkable	☐ Endorses Suicidal/Homicidal Ideation		☐ Delusions
Thought Process:	☐ Linear	☐ Non-linear	☐ Hallucinations/Auditory	
	☐ Flight of ideas	☐ Loose Associations	Visual, Tactile, Olfactory	
Judgement:	☐ Normal	☐ Impaired		

Thank you for completing this form. **Please include any other information you may feel is appropriate on Additional paper.**

Return form to:

WPS
Medical Affairs
1717 W. Broadway, Madison, WI 53713
Phone: (800)333-5003 Fax: (608)226-4711