Phone: (800) 951-7719
Fax: (877) 277-6890

TREATMENT PLAN UPDATE

Member Name:	**Member I.D. Number:**	**Age:**

Treatment To Date: **Request type:** **Routine___** **Urgent ___** **Expedited/Emergent___**

Number of units used: _________ Progress made to date: ☐ *Significant* ☐ *Moderate* ☐ *Minimal* ☐ *None*

Past Treatment:	Mental Health *(Mo / Year)*	Substance Abuse *(Mo / Year)*	Comments
Inpatient (most recent)			
Outpatient (most recent)			

Current Risk of:	Suicidality		Homicidality		Comments
Ideation:	☐ Yes	☐ No	☐ Yes	☐ No	
Plan:	☐ Yes	☐ No	☐ Yes	☐ No	
Prior Attempts:	☐ Yes	☐ No	☐ Yes	☐ No	

Substance Use: *Please check "X" to all that apply.* ☐ None used

Drugs used:	☐ Previously attempted to stop / reduce use ☐ Others are concerned about use	☐ Abstinent and active in recovery program ☐ Cont'd use despite adverse consequences
Frequency/Last use:	☐ Primary focus of treatment	☐ Agrees with abstinence as treatment goal

Coordination of Care: *Every effort is made to contact member's PCP*

Has member's PCP been contacted? ☐ Yes ☐ No
If member refuses to allow coordination of care with PCP, was refusal documented? ☐ Yes ☐ No

Symptoms: *("X" all that apply)*

☐ Anxiety, Panicky	☐ Hopelessness, Tearfulness, Worthlessness	☐ Paranoia
☐ Concentration difficulties	☐ Hyperactivity, Euphoria, Mania	☐ Problem with daily living activities
☐ Depressed mood	☐ Impulsivity	☐ Self-injurious behavior
☐ Decreased energy	☐ Irritability, Inappropriate Anger	☐ Weight change (significant)
☐ Delusions, Hallucinations	☐ Oppositionalism, anti-social behavior	☐ Sleep disturbance
☐ Disrupted thought process	☐ Obsessions / compulsions	☐ Somatic complaints
☐ Other (Specify)		

Medications: ☐ None ☐ Patient Refuses *Prescribed by:* ☐ Psychiatrist ☐ Non-Psychiatrist

Name of Medication	Dosage	Name of Medication	Dosage

Diagnosis:

Axis I:				Axis II:		

Axis III:

Axis IV: Psychosocial and Environmental Problems *(check below)* Axis V: _________ (*current*) _________ (*highest past year*)

☐ Problems- primary support	☐ Occupational problems	☐ Problems with legal system
☐ Marriage	☐ Disability	☐ Housing problems
☐ Relationship	☐ Educational problems	☐ Financial problems
☐ Family	☐ Job performance issues	☐ Problems related to social environment
☐ Peer / friendships	☐ Absenteeism / tardiness	☐ Other psychosocial / environ. problems

Authorization Request:	Monthly	2X / Mo	Weekly	Other	Total Units
☐ 90862	☐	☐	☐	☐	______
☐ 90806	☐	☐	☐	☐	______
☐ 90847	☐	☐	☐	☐	______
☐ other	☐	☐	☐	☐	______

Problems or Symptoms	**Intervention**	**Target Date for Completion**

Provider Printed Name:	**Signature:**	**Phone: ( )**	**Date:**