



BEHAVIORAL HEALTH SYSTEMS

ASSESSMENT REPORT AND TREATMENT PLAN – PHYSICIAN

Patient Name: _____

Date of Birth: ____-____-____

Age: _____
Male Female

Insured Employer: _____

Provider Name: _____

A. Current Problems (Check all that apply):

- Depressed mood, Sleep disturbance, Anhedonia, Guilt, Decreased energy, Poor concentration, Appetite disturbance, Helplessness, Worthlessness, Anxiety, Panic attacks, Obsessions/Compulsions, Dissociative state, Elevated mood, Impaired judgment, Hyperactivity, Impulsiveness, Grandiosity, Distractibility, Irritability, Anger, Delusions, Paranoia, Hallucinations, Agitation, Withdrawn, Memory loss, Confusion, Delirium, Binging, Purging, Weight change, Somatic complaints, Grief, Oppositional, Physical fighting, Learning disability, Marital conflict, Family conflict

Symptoms have been present for:

- < 1 Mo, 1-6 Mos, 7-12 Mos, > 1 Yr

Legal problems: _____

Substance Abuse (including substance, amount, and frequency): _____

B. Previous Treatment History:

Psychiatric

- None, Outpatient, Inpatient, w/in past 12 mos, 2 or more admissions

Substance Abuse

- None, Outpatient, Inpatient, w/in past 12 mos, 2 or more admissions

Medication / Treatment Information (including prior medication and response):

- SI/HI, Plan, Means, Attempt

Describe: _____

- Prior Attempt(s)

Other Dangerous Behaviors: _____

C. Current Level of Functioning (Please rate level of impairment in each area):

Table with 7 columns: None, Minimal, Mild, Moderate, Severe, Profound, Describe. Rows include Marriage/family, Work/school performance, Social, Activities of daily living.

D. DSM-IV-TR Diagnoses:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current Highest in past year Anticipated at discharge

E. Medication Treatment Plan:

Authorization Request: (check one)

Sessions / Frequency

- Medication Management With or Without Brief Therapy (90862/90805), Extended Psychotherapy with Medication Management (90807)

F. Other Services Indicated:

- Individual, Family, Marital/Couples, Group, CD Assessment, Inpatient treatment, Partial hospitalization, Intensive outpatient program, Residential

G. Work Recommendations (if applicable):

Provider's Signature: _____ Date: _____