BEHAVIORAL HEALTHCARE PROGRAM OUTPATIENT TREATMENT REPORT

Patient Information:

Name:_____ID#_____DOB:_____

Provider Information: Therapist Name:_____ Licensure Level:_____

Address:_____City:_____State:_____Zip:_____

Facility/Group: _____Phone:_____ Fax:_____

Diagnosis / Medical Issues (Responses to all questions are required)

Disorder(s) being treated: (Required)
Primary/Secondary Diagnosis:
(Please include Diagnosis Name, Diagnosis Code)

_____

_____

_____

I have reviewed the relationship between medical /mental health issues with the patient. __Yes __No __N/A

Medical Conditions:

___None ___Chronic Pain ___ Cancer___ Obesity

___ Dementia ___Cardiovascular Issues ___Diabetes

___ Asthma/COPD ___ Nicotine/Tobacco Use

Other_____

I have offered referral information/other health information regarding identified health issues to the patient as needed. Yes___ No___

Substance Use/Abuse: Is this patient being treated for substance abuse? ___Yes ___No
Is the goal of treatment abstinence___ or harm reduction___ ? (Please mark the appropriate response)
Is the patient abstinent? ___Yes ___No ___ Participating in self-help groups? ___Yes ___No ___N/A
If not attending self help, have you developed other community supports for this patient? ___Yes ___No ___NA

Symptoms/Symptom Reduction (Responses to all questions are required)

Please complete this section with your patient, collaborating on the report of progress based on symptom reduction for up to two identified symptoms as they relate to the treatment diagnosis. (1=least severe, 10=most severe)

Symptom #1: _____
Severity at start of treatment: 1 2 3 4 5 6 7 8 9 10 Current severity: 1 2 3 4 5 6 7 8 9 10

Symptom #2: _____
Severity at start of treatment: 1 2 3 4 5 6 7 8 9 10 Current severity: 1 2 3 4 5 6 7 8 9 10

Patient's overall level of impairment of functioning on admission (per DSM V): Mild_____ Moderate_____ Severe_____ Very Severe_____
Patient's current overall level of impairment of functioning (per DSM V): Mild_____ Moderate_____ Severe_____ Very Severe_____
PHQ-9 Score (Adult Depressive Diagnosis Only): Baseline _____ Current _____
Is this patient at risk for self harm? Yes___ No___ If yes, is there a safety plan in place? Yes___ No___

Psychotropic Medications	Dosage	Prescriber	Communication with Prescriber
			Yes No No Meds
			Yes No No Meds
			Yes No No Meds

Comments on Treatment Progress:_____

_____

Counselor Required Medication Questions (must be asked at each session with a patient who is taking psychotropic medications):

Providers must indicate that these questions are being asked and acted upon (as noted below) in order to qualify for continued authorizations.

1) Are you taking your medications for the treatment of your mental health issue as prescribed by your medications provider? Yes___ No___
2) Are you finding that the medications continue to be helpful for you? Yes___ No___
3) Are you currently experiencing any unwanted symptoms that you believe could be related to your medications? Yes___ No___
4) Have you discussed any concerns related to your medications with your medications provider? Yes___ No___

If the patient indicates non-compliance/medication problems without communication with the medication provider, the therapist would be required to identify this as a treatment concern with the patient and request permission to fax/mail page 1 of this treatment plan along with a brief message noting the problem to the medication provider.

Patient granted authorization for communication: Yes___ No___ Medication provider was sent notification: Yes___ No___

The patient is currently meeting with me: _____Weekly _____2 x per month ____Every 3 Weeks _____ Monthly ____Less than Monthly

Treatment Type: _____Individual Counseling _____Group Therapy _____Family Therapy _____
_____Medication Management _____Medication Management and Therapy

(Page 1 of this form may be used as faxed/mailed collaborative communication with other providers with your patient's consent.)

Quality of Care / Integrated Care Functions

Please check the responses that apply: (Responses to all questions are required)

The patient was advised of their rights to confidential care and educated about the benefits of an integrated approach to treatment on admission. The patient is aware that they may ask questions regarding confidentiality, integrated care and their treatment at any time. ____Yes ____No

The patient was asked to sign releases to allow collaborative communication by phone/fax/mail with:

Primary Care Provider	Signed ___ Refused ___	Contacted in the last 6 months? Yes___ No___
Psychiatrist/Nurse Practitioner	Signed ___ Refused ___ N/A___	Contacted in the last 6 months? Yes___ No___
Mental Health Professional	Signed ___ Refused ___ N/A___	Contacted in the last 6 months? Yes___ No___
Substance Abuse Professional	Signed ___ Refused ___ N/A___	Contacted in the last 6 months? Yes___ No___
Other Health Related Providers	Signed ___ Refused ___ N/A___	Contacted in the last 6 months? Yes___ No___

(Page 1 of this form may be used as a faxed/mailed collaborative communication form with the patient's consent)

I notified the patient's collateral providers at the start of treatment with me. Yes___ No___

I have attempted contact by phone/fax/mail with these providers as a recommended "best practice" every 6 months. Yes___ No___

I have requested patient feedback on the quality and direction of treatment each time we complete one of these treatment reports together. Yes ___ No ___

Goals /Continued Care / Outcome Planning

Goal/ 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

What measurable indicator(s) are you using to determine that the patient has met their goals in treatment?

_____

_____

What stage of treatment is your patient in currently?

_____ Initiation (Typically just starting treatment, assessment, goal setting, treatment plan development)
_____ Active Treatment (Typically weekly/bi-weekly attendance and working on clear and achievable treatment plan goals)
_____ Continued Care (Typically meeting monthly or less frequently, goals are directed toward protecting treatment gains)
_____ Termination/Discharge Preparation (Typically moving toward closure of this treatment episode)

Is your patient attending sessions regularly? Yes___ No___ If irregular attendance is an issue are you addressing this? Yes___ No___ N/A___
If you don't feel your patient is progressing in treatment, have you consulted others (Clinical Supervisor/Peers?) for assistance or considered referral to another provider? Yes___ No___

What is your estimated time frame for discharge from treatment or transfer to a continued care level for this patient? _____
Are you discussing plans for community support/resources in your sessions as a preparation for discharge or transfer? Yes___ No___

Start Date of New Authorization: _____ Provider Signature: _____ Date: _____

Reviewer Comments: Do Not Write Below this Box; Administrative Use Only

APA Continued Care Criteria 16.1-16.5/16.6

_____

_____

_____

_____

Number of Sessions Authorized:_____ Date Range: _____

_____ _____
Reviewer Signature/Title Date:

PLEASE RETURN TREATMENT PLAN TO: BHCP, 110 FREE STREET, PORTLAND, ME 04101
Phone: 800-538-9698 Fax: (207) 761-3079 Website: BHCP.org