

## **OUTPATIENT TREATMENT REPORT**

Blue Cross Blue Shield of New Mexico 1-800-325-8334, option #2, then option #4

Fax #: 505-816-2603

Check One:	Continuing Outpatient Treatment Report								
DEMOGRAPHICS			DSM IV DIAGNOSIS CODES						
Patient's NameSS #  Date of Birth / Age Gender			Axis I: /_/_/ • /_/// • /_/// • /_/// • /_/// • /_/// • /_/// • //////						
Date of Birth/	Axis IV: Axis V: Current Highest in last year Expected GAF at discharge								
		Ans v. Current Ingliest in last year Expected OAF at discharge							
Subscriber's Name Primary Insurance Plan	(Document specific GAF score – not range)   91-100   Superior function   81-90   Minimal symptoms   71-80   Mild/transient symptoms								
Secondary Insurance Plan Patient's Telephone Number: Home Work			61-70 Mild symptoms 51-60 Moderate symptoms 41-50 Serious symptoms 31-40 Impaired Reality Testing 21-30 Inability to function 01-10 Serious danger of hurting self or others						
N CD (C)									
_	am		Are you independe	ntly licensed	? Ye	es No	)		
Practitioner's Address City	State	7in	Discipline, State License and Number						
			Discipline, State Li	icense and iv	umber				
Telephone Number Fax #:   ASSESSMENT									
Previous Treatment (Please	check all that apply).		Functioning (Ple	ase assess ho	ow current symp	ptoms hav	e affected	the level of in	npairment in the
		following categories)							
<u>Psychiatric</u>	Substance Abuse	<u>Treatment Outcomes:</u>	C	ategories			_	nent Level (C	
None	None					Mild		Moderate	Severe
Outpatient	Outpatient		Relationships			1	2		3
Inpatient	Inpatient		Job/School Perform	nance		1	2		3
Within last 12 months	Within last 12 months		Stressors			1	2		3
2 or more prior admissions	2 or more prior admission		Anger/Behavior			1	2		3
			Physical Health			1	2		3
Symptoms (Please check all that apply. Those not checked will be assumed absent.)			Activities of Daily Hygiene, bathing e		onal	1	2		3
Depressed Mood	Hyperactivity	Emotional/Physical/Sexual Trauma Victim	Eating Habits			1	2		3
	Disruption of Thought	Emotional/Physical/Sexual	Weight Loss	lbs.	Weight Gain		_lbs. l	Height	
Decreased Energy	Process/Content	Trauma Perpetrator	Sleeping Habits			1		2	3
Grief	Delusions	Substance Use (check one)	Difficulty Falling A			g Asleep	Early	Morning Aw	akening
Hopelessness	Hallucinations	Active Substance Abuse	Risk Assessment (						
Worthlessness	Paranoia	Early Full Remission Early Partial Remission	Suicidality:	Not	Ideation	Plan	Means	Prior Attempt	Date
Guilt Anxiety	Dissociative State Oppositionalism	Sustained Full Remission	Homicidiality:	present Not	Ideation	Plan	Means	Prior	Date
Panic Attacks	Somatic Complaints	Sustained Partial Remission	Tiomicianity.	present	racation	1 1411	1.10uns	Attempt	
Obsessions/Compulsions	Concomitant Medical Condition	Other (specify)	Other risk behavior	rs:					
Elevated Mood	Impulsiveness	Other (specify)							
Irritability  Symptoms have been present: Less then 1 month 1-6 months 7-11 months  More then a year									

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Patient   Pati	TREATMENT PLAN							
Production   Symptom   Procused   Complex Care   Prospective Sublication   Measurement Only   Progress in Treatment (Clear Cone)   Continuous vidios of recurrence of acuse presenting symptoms   Nead completion of treatment   Much improved   Near completion of treatment   Near completion of treatment   Near completion of treatment   Near completion of treatment   Near completion   Near completion of treatment   Near completion   Near completion of treatment   Near completion   Near completio	Patient's Name		Clinical Formulation/Other Comments (continued)					
The progres in Transferent (Clack on Management Only Progress in Transferent (Clack on Management Only Progress in Transference of accuse presenting symptoms and discharge from active treatment (Provide anging anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging anging anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging anging anging and maintain stabilization of symptoms and discharge from active treatment (Provide anging	Primary treatment approach (Check one)							
Some what improved	Therapeutic Stabilization Medication M Progress in Treatment (Check one)	anagement Only						
Much improved Other.   Carpeted Treatment Outcomes (Check all that apply)   Carpeted Treatment Outcomes (Check all that apply)   Carpeted Treatment Outcomes (Check all that apply)   Carpeted Check all that apply)   Carpeted Check all that apply   Carpete	Needs support/maintenance only							
Reduction in Symptoms and discharge from active treatment Transfer to self help/other supports and discharge from active treatment Transfer to self help/other supports and discharge from active treatment Transfer to self help/other supports and discharge from active treatment Provide ongoing supportive counseling and maintain stabilization of symptoms Provide ongoing medication management Did Palient concur with goals and strategies of treatment plan? Yes No Medication (fixed in Providency and other medications (f application) Has patient been evaluated for medications of phythoropic and other medications (f application) Has patient been evaluated for medication segme? Yes No Current MEDICATION: None Psychotropic Medical Other Systems of Medication (discute if PCP or Psychiatristy) Prescribing physician (indicate if PCP or Psychiatristy)  Prescribing physician (indicate if PCP or Psychiatristy)  Clinical Formulation/ Other commens  Use specific behavioral descriptors to address additional clinical information that impacts treatment (e.g. progression of symptoms, text results/lab values, pertinent history, concomitant issues, factors impelling progress, effectiveness of current strategies).  Treating Provider's Signature:  Paraling Provider's Signature:  Date South Treating Provider's Signature:  Date of Authorization:  Date Substitution Provider Signature:  Date of Authorization:  Date Substitution Substitution in Substitution of Sub	_							
Return to highest GAP and discharge from active treatment Provide ongoing supportive counseling and maintain stabilization of symptoms Provide ongoing medication management Provide ongoing medication management Provide ongoing supportive counseling and maintain stabilization of symptoms Provide ongoing medication management Provide ongoing supportive counseling and maintain stabilization of symptoms Provide ongoing supportive counseling and maintain stabilization of symptoms Provide ongoing medication management Provide ongoing medication management Provide ongoing medication management Provide ongoing supportive counseling and maintain stabilization of symptoms  Medication (its all psychotropic and other medications) from place in the patient been evaluated for medications of symptoms.  Medication (indicate in PCP or Psychotripic)  Medication (indicate in PCP or Psychiatrist)  None Psychotropic Medication regime? Ves. No Yes. No Yes. No Yes. No Current Mosage Frequency  None Medication (indicate in PCP or Psychiatrist)  None Symptoms (indicate in PCP or Psychiatrist)  None Symptoms (indicate in PCP or Psychiatrist)  None Symptoms (indicate in PCP or Psychiatrist)  None Medication (indicate in PCP or Psychiatrist)  None Medication (indicate in PCP or Psychiatrist)  None Symptoms (indicate in PCP or Psychiatrist)  None Medication (indicate in PCP or Psychiatrist)  None Individual Group EAP Medication Management (indicate treatment (indicate treatment)  None Individual Group EAP Medication (indicate treatment)  N	_							
Return to highest GAF and discharge from active treatment   Transfer to self helpsother supports and discharge from active treatment   Provide ongosing supportive counseling and mismatin stabilization of symptoms   Provide ongosing medication management   Did Patient concur with goals and strategies of treatment plan? Yes No   Transfer   Psychotropic and other medications if applicable)   Psychotropic and other psychotro	<b>Expected Treatment Outcomes</b> (Check al.	l that apply)						
Treatment Frequency & Duration   Provided ongoing supportive counseling and maintain stabilization of symptoms   Provided ongoing properties of treatment plane?   Yes_   No_   Position (first all pyrichetropic and other medications? Yes_   No_   Position (first all pyrichetropic and other medications? Yes_   No_   Position (first all pyrichetropic and other medications? Yes_   No_   Position (first all pyrichetropic and other medications? Yes_   No_   Position (first all pyrichetropic and other medications? Yes_   No_   Position (first all pyrichetropic and other medications? Yes_   No_   Position (first all pyrichetropic and other medications? Yes_   No_   Position (first all pyrichetropic and other medication? Yes_   No_   Position (first all pyrichetropic and other medication? Yes_   No_   Position (first all pyrichetropic and other medication? Yes_   No_   Position (first all pyrichetropic and other medication? Yes_   No_   Position (first all pyrichetropic and other medication? Yes_   No_   Position (first all pyrichetropic and other medication? Yes_   No_   Position (first all pyrichetropic and other medication? Yes_   No_   None   Position (first all pyrichetropic and other medication? Yes_   No_   None   Position (first all pyrichetropic and other medication? Yes_   No_   None   Position (first all pyrichetropic and other medication? Yes_   None   Position (first all pyrichetropic and other medication? Yes_   None   Position (first all pyrichetropic and other medication? Yes_   None   Position (first all pyrichetropic and other medication? Yes_   No.   Position (first all pyrichetropic and other medication? Yes_   No.   Position (first all pyrichetropic and other medication? Yes_   No.   Position (first all pyrichetropic and other medication? Yes_   No.   Position (first all pyrichetropic and other medication? Yes_   No.   Position (first all pyrichetropic and other medication? Yes_   No.   Position (first all pyrichetropic and other medication? Yes_   No.   Position (first all pyrichetropic and other	Reduction in symptoms and discharge from	active treatment						
Provide ongoing supportive counseling and stategies of treatment plan?   Yes   No   Side   Treatment   Provide ongoing medication management   Yes   No   No   Medication (list all psychotropic and other medications if applicable)   Yes   No   No   Side   Treatment   Provide   No   No   No   No   No   No   No   N	Return to highest GAF and discharge from a	active treatment						
Provide ongoing medication management	Transfer to self help/other supports and disc	charge from active treatment						
Did Patient concur with goals and strategies of treatment plan? Yes No to Medication (list all psychotropic and other medications if applicable)  As patient been evaluated for medication:  Yes No Psychotropic Medical Other	Provide ongoing supportive counseling and	maintain stabilization of symptoms						
Date First Seen   Date First Seen   Date Last Seen   Date First Seen   Date All Number of Visits Used to Date for this Course of Teatment Course.    Seen	Provide ongoing medication management							
Total Number of Visits Used to Date for this Course of Treatment   Strianted Total Visits of entire Course of Treatment	Did Patient concur with goals and strategies	s of treatment plan? Yes No	Treatment Frequency & Duration					
Current MEDICATION:   None	Medication (list all psychotropic and other	medications if applicable)	Date First Seen Date Last Seen Date First Seen this Yr					
No.	Has patient been evaluated for medication?	Yes No	Total Number of Visits Used to Date for this Course of Treatment					
Prescribing physician (indicate if PCP or Psychiatrist):	Current MEDICATION: None	Psychotropic Medical Other	Estimated Total Visits of entire Course of Treatment					
Name of Medication Current Dosage/Frequency Start Date Side Effects  Yes No Yes No Group Therapy (60-90 min) 90806  Yes No Other  Clinical Formulation/ Other comments Use specific behavioral descriptors to address additional clinical information that impacts treatment impeding progress, effectiveness of current strategies).  Treating Provider's Signature:  Bale Alba Professional Reviewer:  Bale Bligibility Verified:  Psychotherapy (45-50 min) 90806  Group Therapy (60-90 min) 90853  Group Therapy (60-90 min) 90853  Group Therapy (60-90 min) 90853  Group Therapy (60-90 min) 90866  Group Therapy (60-90 min) 90806  Group Th	Does patient follow medication regime?	Yes No	Frequency Estimated					
Psychotherapy (45-50 min) 90806   Group Therapy (60-90 min) 90853   Grou	Prescribing physician (indicate if PCP or Ps	ychiatrist):	(i.e., 1x/wk., 1x/mo., etc.) Discharge Date					
Group Therapy (60-90 min) 90853    Comparison of Secretary (60-90 min) 90853   Comparison (60-90 min) 90854   Comp	Name of Medication Current Dosas	ge/Frequency Start Date Side Effects						
Group Therapy (60-90 min) 90853    Comparison of Secretary (60-90 min) 90853   Comparison (60-90 min) 90854   Comp		Yes No	Psychotherapy (45-50 min) 90806					
Other		37 N						
Other   Othe								
Describe side effects/interventions:  Clinical Formulation/ Other comments Use specific behavioral descriptors to address additional clinical information that impacts treatment (e.g. progression of symptoms, text results/lab values, pertinent history, concomitant issues, factors impeding progress, effectiveness of current strategies).  What other treatment or community services is the patient receiving? None Individual Group EAP Medication Management  Family AA/NA Structured Program Other  Medical Treatment (Date of Last Physical Examination) Last date of contact to coordinate treatment: Behavioral Are other family members in treatment? Yes_No_With You? Yes_No_  Treating Provider's Signature:  Date:    Date   Date		V N	Other					
Clinical Formulation/ Other comments Use specific behavioral descriptors to address additional clinical information that impacts treatment (e.g. progression of symptoms, text results/lab values, pertinent history, concomitant issues, factors impeding progress, effectiveness of current strategies).  What other treatment or community services is the patient receiving?  None Individual Group EAP Medical Town Management of Contact to Coordinate treatment:    Medical Treatment (Date of Last Physical Examination)	Describe side effects/interventions:							
Use specific behavioral descriptors to address additional clinical information that impacts treatment (e.g. progression of symptoms, text results/lab values, pertinent history, concomitant issues, factors impeding progress, effectiveness of current strategies).  What other treatment or community services is the patient receiving?  None Individual Group EAP Medication Management Family AA/NA Structured Program Other Medical Treatment (Date of Last Physical Examination)  Last date of contact to coordinate treatment: Behavioral Are other family members in treatment? Yes No With You? Yes No Dates  For Blue Cross Blue Shield of New Mexico Use Only  MHSA Professional Reviewer: Dates of Authorization: to			Other					
(e.g. progression of symptoms, text results/lab values, pertinent history, concomitant issues, factors impeding progress, effectiveness of current strategies).    None								
impeding progress, effectiveness of current strategies).  Family AA/NA Structured Program Other  Medical Treatment (Date of Last Physical Examination)  Last date of contact to coordinate treatment: Behavioral Are other family members in treatment? Yes No With You? Yes No Dates  For Blue Cross Blue Shield of New Mexico Use Only  MHSA Professional Reviewer:  Dates of Authorization:  Eligibility Verified: Date Authorized:  Input/Tech:								
Medical Treatment (Date of Last Physical Examination)  Last date of contact to coordinate treatment: Behavioral Are other family members in treatment? Yes No With You? Yes No With You? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No With You? Yes No Are other family members in treatment? Yes No A			1					
Last date of contact to coordinate treatment: Behavioral Medical Are other family members in treatment? Yes No With You? Yes No  Treating Provider's Signature: Date:    For Blue Cross Blue Shield of New Mexico Use Only			1 •					
Are other family members in treatment? Yes_ No_ With You? Yes_ No_  Treating Provider's Signature:  Date:  For Blue Cross Blue Shield of New Mexico Use Only  MHSA Professional Reviewer:  Dates of Authorization:  Eligibility Verified: Date Authorized:  Input/Tech:								
Treating Provider's Signature:    Date:								
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Authorization Number: Eligibility Verified: Date Authorized: Input/Tech:	·							
	MHSA Professional Reviewer:							
Approved: Approved with Modification: Denied: Reason: Medical Director:	Authorization Number: Eligibility Verified: Date Authorized: Input/Tech:							

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