Blue Cross and Blue Shield of New Mexico

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: **Initial Outpatient Treatment Report** | **Continuing Outpatient Treatment Report**

DEMOGRAPHICS

Patient's Name _____SS #_____

Date of Birth _____/_____/_____ Age_____ Gender_____

Subscriber's Name _____Subscriber's # _____
Primary Insurance Plan _____

Secondary Insurance Plan _____
Patient's Telephone Number: Home _____ Work _____

DSM IV DIAGNOSIS CODES

Axis I: / __/ __/ __ • / __/ __/ / __/ __/ __/ • / __/ __/ / __/ __/ __/ • / __/ __/
Axis II: / __/ __/ __ • / __/ __/ / __/ __/ __/ • / __/ __/ / __/ __/ __/ • / __/ __/
Axis III: _____
Axis IV: _____
Axis V: Current____ ___ Highest in last year____ ___ Expected GAF at discharge____ ___

(Document specific GAF score – not range)

91-100	Superior function	81-90	Minimal symptoms	71-80	Mild/transient symptoms
61-70	Mild symptoms	51-60	Moderate symptoms	41-50	Serious symptoms
31-40	Impaired Reality Testing	21-30	Inability to function	11-20	Some danger
01-10	Serious danger of hurting self or others				

Name of Practitioner / Program _____
Practitioner's Address _____
City_____ State_____ Zip_____
Telephone Number _____ Fax #: _____

Are you independently licensed? Yes No

Discipline, State License and Number _____

ASSESSMENT

Previous Treatment *(Please check all that apply).*

Psychiatric	Substance Abuse	Treatment Outcomes:
None	None	_____
Outpatient	Outpatient	_____
Inpatient	Inpatient	_____
Within last 12 months	Within last 12 months	_____
2 or more prior admissions	2 or more prior admission	_____

Symptoms *(Please check all that apply. Those not checked will be assumed absent.)*

Depressed Mood	Hyperactivity	Emotional/Physical/Sexual Trauma Victim
Decreased Energy	Disruption of Thought Process/Content	Emotional/Physical/Sexual Trauma Perpetrator
Grief	Delusions	Substance Use (check one)
Hopelessness	Hallucinations	Active Substance Abuse
Worthlessness	Paranoia	Early Full Remission
Guilt	Dissociative State	Early Partial Remission
Anxiety	Oppositionalism	Sustained Full Remission
Panic Attacks	Somatic Complaints	Sustained Partial Remission
Obsessions/Compulsions	Concomitant Medical Condition	Other (specify)_____
Elevated Mood	Impulsiveness	Other (specify) _____
Irritability		

Symptoms have been present: Less then 1 month 1-6 months 7-11 months More then a year

Functioning *(Please assess how current symptoms have affected the level of impairment in the following categories)*

Categories	Impairment Level (Circle level)		
	Mild	Moderate	Severe
Relationships	1	2	3
Job/School Performance	1	2	3
Stressors	1	2	3
Anger/Behavior	1	2	3
Physical Health	1	2	3
Activities of Daily Living (personal Hygiene, bathing etc.)	1	2	3
Eating Habits	1	2	3

Weight Loss _____lbs. Weight Gain _____lbs. Height _____

Sleeping Habits	1	2	3

Difficulty Falling Asleep Difficulty Staying Asleep Early Morning Awakening

Risk Assessment *(Check all that apply)*

Suicidality: Not present Ideation Plan Means Prior Attempt Date _____
Homicidiality: Not present Ideation Plan Means Prior Attempt Date _____

Other risk behaviors : _____
_____

_____

TREATMENT PLAN

Patient's Name_____

Primary treatment approach *(Check one)*

Problem focused Symptom Focused Complex Case
Therapeutic Stabilization Medication Management Only

Progress in Treatment *(Check one)*

Continues with/or recurrence of acute presenting symptoms
Needs support/maintenance only
Somewhat improved Near completion of treatment
Much improved Other: _____

Expected Treatment Outcomes *(Check all that apply)*

Reduction in symptoms and discharge from active treatment
Return to highest GAF 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 Patient concur with goals and strategies of treatment plan? Yes____ No____

Medication *(list all psychotropic and other medications if applicable)*

Has patient been evaluated for medication? Yes No

Current MEDICATION: None____ Psychotropic____ Medical Other _____

Does patient follow medication regime? Yes___ No___

Prescribing physician (indicate if PCP or Psychiatrist):_____

Name of Medication	Current Dosage/Frequency	Start Date	Side Effects
			Yes No
			Yes No
			Yes No
			Yes No

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).

_____
_____
_____

Clinical Formulation/Other Comments *(continued)*

_____
_____
_____
_____
_____
_____
_____

Treatment Frequency & Duration

Date First Seen_____ Date Last Seen_____ Date First Seen this Yr._____

Total Number of Visits Used to Date for this Course of Treatment_____

Estimated Total Visits of entire Course of Treatment _____

	Frequency (i.e., 1x/wk., 1x/mo., etc.)	Estimated Discharge Date
Psychotherapy (45-50 min) 90806		
Group Therapy (60-90 min) 90853		
Other		
Other		

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 _____ 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

MHSA Professional Reviewer:_____Dates of Authorization: _____ to _____

Authorization Number: _____ Eligibility Verified: Date Authorized: _____ Input/Tech: _____

Approved: Approved with Modification: Denied: Reason: _____ Medical Director: _____