TREATMENT CONTINUATION REQUEST FORM BEHAVIORAL HEALTH UNIT

Please fax to: Behavioral Health Unit: 740.699.6255 · Toll Free: 1.866.616.6255
*All Sections must be completed for timely approval

Patient Name:	
Member ID:	Date of Birth:

Provider Name:	
Phone Number:	NPI#:
Address:	

Date of Evaluation Visit for current Episode of Care: ____________ Is this request urgent? ☐ Yes ☐ No

ASSESSMENT:	
Clinical Disorders/Syndromes	Diagnoses Code:
Personality Disorders/Intellectual Disabilities	Diagnoses Code:

Relevant Medical Issues/Physical Problems

Does the patient have a current medical condition linked to the Axis 1 or 2 diagnoses?

☐ Yes ☐ No Describe:

Psychosocial Stressors

Please indicate the severity of current Psych Social Stressors:

☐ None ☐ Mild ☐ Moderate ☐ Severe

GAF Score Highest Past Year: Current:

CURRENT MEDICATIONS:			
☐ Anti-Pyschotic	☐ Anti-Anxiety	☐ Anti-Depressant	☐ None
☐ Hypnotic	☐ Mood Stabilizer	☐ Medical	
☐ Psycho-Stimulant	☐ Other/Comments:		

RISK ASSESSMENT:				
Suicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None
Homicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None

SYMPTOMS: (IF PRESENT, CHECK DEGREE)

	Mild	Moderate	Severe		Mild	Moderate	Severe
Depressed Mood	☐	☐	☐	Anxiety	☐	☐	☐
Anhedonia	☐	☐	☐	Panic Attacks	☐	☐	☐
Low Energy	☐	☐	☐	Inattention	☐	☐	☐
Hopelessness	☐	☐	☐	Impulsive	☐	☐	☐
Somatoform/	☐	☐	☐	Bingeing/Purging	☐	☐	☐
Factitious Problems	☐	☐	☐	Restricting Food Intake	☐	☐	☐
Social Isolation	☐	☐	☐	Hyperactive	☐	☐	☐
Self Mutilation	☐	☐	☐	Hallucination	☐	☐	☐
Sleep Disturbance	☐	☐	☐	Delusions	☐	☐	☐
Mood Swings	☐	☐	☐	Other Psychotic Symptoms	☐	☐	☐
Obsessions/Compulsions	☐	☐	☐	No Symptoms	☐		

SUBSTANCE ABUSE/ADDICTIONS:

☐ Active Drug Use	☐ Guilt/Remorse/Shame	☐ Abuse in Remission
☐ Cravings	☐ Preoccupation with getting high	☐ None
☐ Drug Seeking Behavior	☐ Preoccupation with Gambling	

Is this patient on mental health or chemical dependency disability? ☐ Yes ☐ No

Have you contacted the patient's PCP? ☐ Yes ☐ No

Have you contacted any other health care provider? ☐ Yes ☐ No

If "Yes", list who? ______________________________

Other Provider: ______________________________

INTERVENTIONS & GOALS USED IN TREATMENT:

1. ______________________________

Time Frame to Complete: ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ Other

2. ______________________________

Time Frame to Complete: ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ Other

3. ______________________________

Time Frame to Complete: ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ Other

SPECIFIC SERVICES REQUESTED AND NUMBER OF SERVICES REQUESTED:					
Code:	No. of Services	Code:	No. of Services	Code:	No. of Services
90791		90833		90846	
90792		90836		90847	
90832		90838		90853	
90834		90785			
90837					
E&M Code:		No. of Services:			

FREQUENCY OF APPOINTMENTS SCHEDULE:
☐ Weekly ☐ 2 x a month ☐ Monthly ☐ Other:

LEVEL OF IMPROVEMENT TO DATE:			
☐ None	☐ Minor	☐ Moderate	☐ Major

ADDITIONAL SYMPTOMS, FUNCTIONING LEVEL AND COMMENTS:

Provider Signature: ______________________________ Date: ______________

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