



NEW AVENUES / MBHN:

Outpatient Treatment Report – Authorization Request

Employee Assistance Program · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980
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<p style="text-align: center;">When to submit this form: MBHN ⇔ For Additional Sessions; EAP ⇔ For Additional Insurance Sessions</p>	<p>II. Type of Initial Referral:</p> <p><input type="checkbox"/> MBHN Self Referral</p> <p><input type="checkbox"/> EAP Self Referral</p> <p><input type="checkbox"/> Employer Referral</p>	<p>III. DSM-IV Diagnosis: (required)</p> <p>AXIS I: Primary: _____ Secondary: _____</p> <p>AXIS II: Primary: _____ Secondary: _____</p> <p>AXIS III: _____</p> <p>AXIS IV: _____</p> <p>AXIS V: (current GAF): _____</p> <p>AXIS V: (past year GAF): _____</p>																												
<p>I. Demographics: Request Date: _____</p> <p>Client Name: _____ Birth Date: _____</p> <p>Employer: _____ SSN/Case #: _____</p>	<p>Global Assessment of Functioning (GAF) Scale</p> <p>91-100 Superior Functioning</p> <p>81-90 Minimal Symptoms</p> <p>71-80 Mild/Transient Symptoms</p> <p>61-70 Mild Symptoms</p> <p>51-60 Moderate Symptoms/Moderate Living Impairment</p> <p>41-50 Serious Symptoms/Serious Living Impairment</p> <p>31-40 Impaired Reality Testing/Major Living Impairment</p> <p>21-30 Inability to Function in Almost All Areas of Life</p> <p>11-20 Some danger to self/others</p> <p>01-10 Serious danger to self/others</p>																													
<p>IV. Medication: (List all psychotropic & other medications) Not Assessed []</p> <p>Has the patient been evaluated for medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Prescribing Physician: _____</p> <p>Current Medication: <input type="checkbox"/> None <input type="checkbox"/> Psychotropic <input type="checkbox"/> Medical <input type="checkbox"/> Other: _____</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Medication</u></th> <th style="text-align: left;"><u>Dosage/Frequency</u></th> <th style="text-align: left;"><u>Start Date</u></th> <th style="text-align: left;"><u>Medication</u></th> <th style="text-align: left;"><u>Dosage/Frequency</u></th> <th style="text-align: left;"><u>Start Date</u></th> </tr> </thead> <tbody> <tr> <td>① _____</td> <td></td> <td></td> <td>⑤ _____</td> <td></td> <td></td> </tr> <tr> <td>② _____</td> <td></td> <td></td> <td>⑥ _____</td> <td></td> <td></td> </tr> <tr> <td>③ _____</td> <td></td> <td></td> <td>⑦ _____</td> <td></td> <td></td> </tr> <tr> <td>④ _____</td> <td></td> <td></td> <td>⑧ _____</td> <td></td> <td></td> </tr> </tbody> </table>			<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Start Date</u>	<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Start Date</u>	① _____			⑤ _____			② _____			⑥ _____			③ _____			⑦ _____			④ _____			⑧ _____
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<p>V. OTHER SERVICES : (What other services is the client using?) Not Assessed []</p> <p><input type="checkbox"/> EAP <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> Medication Management <input type="checkbox"/> Self Help Group <input type="checkbox"/> Structured Program</p> <p><input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____</p>	<p>VII. Provider Coordination of Care with PCP:</p> <p><input type="checkbox"/> Patient has signed consent form</p> <p><input type="checkbox"/> Patient declined to sign consent form</p> <p><input type="checkbox"/> Provider has not discussed consent form with Patient</p> <p>Communicated with PCP by:</p> <p><input type="checkbox"/> Verbal</p> <p><input type="checkbox"/> Written</p> <p>Date of communication with PCP: _____</p> <p><input type="checkbox"/> Did not communicate with PCP</p>																													
<p>VI. CHANGES: What changes does the client still need to make which require continued treatment?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Vocational\Financial</u></th> <th style="text-align: left;"><u>Social</u></th> <th style="text-align: left;"><u>Physical</u></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Financial Situation</td> <td><input type="checkbox"/> Marriage</td> <td><input type="checkbox"/> Friends</td> </tr> <tr> <td><input type="checkbox"/> Job Performance</td> <td><input type="checkbox"/> Significant Other</td> <td><input type="checkbox"/> Co-Workers</td> </tr> <tr> <td><input type="checkbox"/> School Performance</td> <td><input type="checkbox"/> Family</td> <td><input type="checkbox"/> Legal</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Overall Physical Health</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Eating Habits</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Activities of Daily Living</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Sleeping Habits</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Sexual functioning</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Leisure Time Activities</td> </tr> </tbody> </table> <p>Other:</p> <p><input type="checkbox"/> Medical Concern: _____</p> <p><input type="checkbox"/> Psychological Concern: _____</p> <p><input type="checkbox"/> Other: _____</p>			<u>Vocational\Financial</u>	<u>Social</u>	<u>Physical</u>	<input type="checkbox"/> Financial Situation	<input type="checkbox"/> Marriage	<input type="checkbox"/> Friends	<input type="checkbox"/> Job Performance	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Co-Workers	<input type="checkbox"/> School Performance	<input type="checkbox"/> Family	<input type="checkbox"/> Legal			<input type="checkbox"/> Overall Physical Health			<input type="checkbox"/> Eating Habits			<input type="checkbox"/> Activities of Daily Living			<input type="checkbox"/> Sleeping Habits			<input type="checkbox"/> Sexual functioning	
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VIII. CURRENT TREATMENT GOALS :

PROBLEM #1: _____

TX GOAL #1: _____

PROGRESS: _____

EVALUATION QUESTION: "TO WHAT EXTENT DID THE CLIENT EXPERIENCE A POSITIVE CHANGE WHEN IT CAME TO RESOLVING THE IDENTIFIED PROBLEM?"

1.0 ----- 1.5 ----- 2.0 ----- 2.5 ----- 3.0 ----- 3.5 ----- 4.0 ----- 4.5 ----- 5.0
 NO MILD MODERATE PRONOUNCED PROBLEM
 CHANGE CHANGE CHANGE CHANGE RESOLUTION

TX Modalities: Individual Family Couple Group Other Self- Help/Community

Frequency of Sessions: Weekly Every 2 Weeks Monthly Quarterly Other

Estimated Date of Completion: _____

PROBLEM #2: _____

TX GOAL #2: _____

PROGRESS: _____

EVALUATION QUESTION: "TO WHAT EXTENT DID THE CLIENT EXPERIENCE A POSITIVE CHANGE WHEN IT CAME TO RESOLVING THE IDENTIFIED PROBLEM?"

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IX. EXPECTED TREATMENT OUTCOME:

(check all that apply)

Goal #1 Goal #2 Goal #3

- Symptom reduction & discharge from active treatment.
- Return to highest level of functioning before onset of current problem(s) & discharge from active treatment.
- Transfer to self help group or other support services & discharge from active treatment.
- Provide ongoing supportive counseling & maintain stabilization of symptoms.
- Provide ongoing medication management.

NUMBER of SESSIONS REQUESTING NOW: _____ DATE AUTHORIZATION SHOULD BEGIN: _____

EXPECTED DATE of COMPLETION (Month/Year): _____

Provider's Name (Print): _____ Provider's Signature: _____ Date Signed: _____