

**IDENTIFYING DATA**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sponsor #: \_\_\_\_\_

**DSM-IV TR Diagnosis**

Axis I - \_\_\_\_ . \_\_\_\_ / \_\_\_\_ . \_\_\_\_ / \_\_\_\_ . \_\_\_\_ Axis II - \_\_\_\_ . \_\_\_\_ / \_\_\_\_ . \_\_\_\_ Axis III - \_\_\_\_\_

Date first seen: \_\_\_\_\_ Date last seen: \_\_\_\_\_ Anticipated # of sessions to complete treatment: \_\_\_\_\_

**TREATMENT REPORT**

***Current Clinical Information:*** ( Circle each. Scale 0=None 1=Mild 2=Moderate 3=Severe 4=Extreme )

Aggression	0 1 2 3 4	Impulsivity	0 1 2 3 4
Alcohol /Substance Use	0 1 2 3 4	Job / School Problems	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4	Mania	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Medical Illness	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Memory	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Delusions	0 1 2 3 4	Side Effects	0 1 2 3 4
Depression	0 1 2 3 4	Sleep Disturbance	0 1 2 3 4
Hallucinations	0 1 2 3 4	Weight Loss/Gain	0 1 2 3 4
Current Stressors: _____		Other _____	

***Treatment Plan/Discharge Planning Goals:***

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

***Medications: (Optional for Non-Physicians)***

**TYPE OF TREATMENT**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Behavior Modification          | <input type="checkbox"/> Group Therapy               | <input type="checkbox"/> Reality Therapy            |
| <input type="checkbox"/> Client Centered                | <input type="checkbox"/> Interpersonal               | <input type="checkbox"/> Relaxation Techniques      |
| <input type="checkbox"/> Cognitive-Behavioral           | <input type="checkbox"/> Medication Management       | <input type="checkbox"/> Social Skills Training     |
| <input type="checkbox"/> Dialectical Behavioral Therapy | <input type="checkbox"/> Parent Training             | <input type="checkbox"/> Supportive                 |
| <input type="checkbox"/> Educational                    | <input type="checkbox"/> Psychodynamic Psychotherapy | <input type="checkbox"/> Systematic Desensitization |
| <input type="checkbox"/> Exposure/Response Prevention   | <input type="checkbox"/> Rational Emotive            | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Family Therapy                 |  |   |

**REQUESTED SERVICES:**

**CPT Code:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**CPT Code:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

Provider Name: \_\_\_\_\_ Phone# : (\_\_\_\_) \_\_\_\_\_ Fax#: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Licensure

\_\_\_\_\_  
Date

***Disclaimer: Authorization indicates that ValueOptions-TRICARE has determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered.***