MODERN ASSISTANCE
EMPLOYEE ASSISTANCE PROGRAM
EST. 1988

Jennifer Ribeiro
300 Congress St Suite 104
Quincy, MA 02169
jribeiro@modernassistance.com
P: 617-774-0331 x224
F: 617-774-0336

OUTPATIENT MENTAL HEALTH TREATMENT REQUEST FORM

***Provider Info**:*
Name :________________________________NPI #____________________ License # _______________________

Agency Name__________________________ Address:________________________ Phone #____________________

Payment Address:____ TX ID __________________________

Provider Email Address____

Provider Specialities____

Client Info:

Name:__________________________________ Insured ID#___________________ DOB:______________________

Phone #______________________

Policy Holders Name_____________________ DOB_________________ Social security #________________________

Medical Issues____

Diagnostic Formulation ICD-10CM

Diagnosis (write out full name):____Diagnosis Code:_____________

Please describe current symptoms:____

____

Risk Severity Index

	None	Mild	Moderate	Severe
Harm to self/others ❑	❑	❑	❑	❑
Substance Abuse	❑	❑	❑	❑
Psychosis	❑	❑	❑	❑
Medical Issues	❑	❑	❑	❑

Symptom Severity Index

	WNL	Mild	Moderate	Severe
Depression / Anxiety	❑	❑	❑	❑
Social Functioning	❑	❑	❑	❑
Impulsivity	❑	❑	❑	❑
ADL's / Self Care	❑	❑	❑	❑

Has the member had a psychiatric evaluation? **Yes** **No** **Planned** **Unknown**

Current Medications and dosage	**Medication Compliance**			**Prescriber**			
	Yes	No	Unknown	Psychiatrist	ARNP	PCP	Other
______________________________	❑	❑	❑	❑	❑	❑	❑
______________________________	❑	❑	❑	❑		❑	❑
______________________________	❑	❑	❑	❑		❑	❑

Treatment Information

Requested Treatment Start Date:_______________ ***Date of initial session:***_____________

***Expected Treatment** (TX) Outcome:*_____ problem resolution _____ symptom reduction _____ maintenance

***TX modalities** requested by you:* _____ individual _____ family _____ group _____ medication management

***Frequency of TX requested**: Weekly_______ Bi -Weekly________ Monthly_________*

***Estimated Sessions to TX completion**:* _______________

Please document the following:

Treatment Plan:

____

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____

____

____

____

Progress:

____

____

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Barriers for treatment goals: