

MODERN ASSISTANCE
EMPLOYEE ASSISTANCE PROGRAM
EST. 1988

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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 |
|-------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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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:

Progress:

Barriers for treatment goals:
