



REQUEST FOR MEDICATION MANAGEMENT SESSIONS

Patient's Name:		Member ID:	
DOB: / /	Age:	Date of Initial appointment: (/ /)	
Name of Psychiatrist:			
Completed By:		Date Completed:	
Coordination of Care with other treatment providers? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, provider's name:			
DSM IV Diagnosis (Please complete all axes)			
Axis I: _____			
Axis II: _____			
Axis III: Medical Problems: _____			

Medication	Initial Dosage and Date	Current Dosage	Clinical Indications for Medication	Side Effects
Past medications attempted	Initial Dosage and Date	Maximum Dosage	Reasons for Discontinuing	

Prognosis: _____

List all relevant laboratory test results: (e.g., Serum levels, UDS, pregnancy, etc.; include EKG if applicable): _____

Therapy/Med management Therapy only Med management only

Frequency: _____ # of visits _____

Physician (Print Name): _____

Telephone: _____ Fax: _____

Physician's Signature: _____ Date: _____

Patient/Member Authorization: I am in agreement with my provider's request for additional sessions from my annual number.

Signature Date