



Outpatient Treatment Report

Provider Name _____ Signature _____

Telephone _____ Fax _____ Date _____

Patient Information

Patient Name		Member ID
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Health Plan
Current Identified Problem(s)		

Functioning

Please assess how current symptoms have affected the level of impairment in the following categories:

Categories	Impairment Level (Circle Level)		
	Mild	Moderate	Severe
Relationships	1	2	3
Job/School Performance	1	2	3
Social	1	2	3
Physical Health	1	2	3
Activities of Daily Living (hygiene, bathing, etc.)	1	2	3
Eating Habits	1	2	3

Risk Assessment *(check all that apply)*

Factor	Not Present	Ideation	Plan	Means	Prior Attempt	Date
Suicidality						
Homicidality						

Concurrent S/A	Alcohol	Marijuana	Stimulants	Opiates	Other

Diagnostic Information

Axis I:	
Axis II (Pers. Dis/MR):	
Axis III (Medical):	
Axis IV (Stressors):	
Axis V (Level of Functioning):	Current ____ Past Year ____

Treatment Plan, Frequency, and Duration

Date First Seen	Date Last Seen
Service Requested	Frequency

Prior authorization is required to see the member more than weekly

Provider Name _____ Patient Name _____

Medication

Has patient been evaluated for medication?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has patient refused medication evaluation?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of Prescribing Physician				<input type="checkbox"/> PCP	<input type="checkbox"/> Psychiatrist
<i>List all current psychotropic medications</i>					
Medication	Dosage/ Frequency	Start Date	Medication	Dosage/ Frequency	Start Date

Treatment Goals

*List goals directed at reducing risk and impairment to functioning as reported on page 1.
Use Progress Rating Scale, below, when addressing Methods for Achieving Goals.*

<u>Progress Rating Scale</u>		
1 = Much Worse	3 = No Change	5 = Great Improvement
2 = Somewhat Worse	4 = Slight Improvement	6 = Resolved

Measurable Behavioral Goals
1.
2.
3.

Methods for Achieving Goal #1:
Progress Since Last Report (Progress Rating # _____)

Methods for Achieving Goal #2:
Progress Since Last Report (Progress Rating # _____)

Methods for Achieving Goal #3:
Progress Since Last Report (Progress Rating # _____)

Discharge Criteria (<i>specific and measurable</i>)
Additional Comments

Mail completed form to:
ATTN: Case Management
Mesa Mental Health
PO BOX 90607, Albuquerque, NM 87199-0607
Fax completed form to: (505) 816-6702
Questions? Call (505) 816-6792 in Albuquerque or toll free 1-800-583-6372