Companion Benefit Alternatives, Inc.

Phone: 800-868-1032
Fax: 803-714-6456
www.CompanionBenefitAlternatives.com

SC DMH Continued Outpatient Mental Health Treatment Request Form

NOTE: CBA will not accept referrals for psychological testing on this form. Please use the CBA Psychological Testing Pre-Authorization Request Form.

** required information*

Clinic's Name*: _____ Phone*: _____

Mailing Address 1*: _____ Fax*: _____

Mailing Address 2: _____ E-mail*: _____

City*: _____ State*: _____ ZIP Code*: _____

Clinic's NPI*: _____

Contact's First Name: _____ Contact's Last Name: _____

Contact's Extension*: _____

Patient's First Name*: _____ **Patient's Last Name***: _____

Date of Birth*: _____ **ID Card Number*:** _____

Phone: _____ **E-mail**: _____

Patient's CIN: _____

Diagnosis
Axis I*: _____
_____
Axis II: _____
Axis III: _____
Axis IV: _____
_____
Axis V: Initial GAF*: _____
Current GAF*: _____
Treatment Start Date*:
_____

Harm Issues*: ☐ None ☐ Self ☐ Others

Please check all that apply*:
☐ Thoughts of passively dying
☐ Active thoughts
☐ Endorses intent
☐ Endorses plan

If diagnosis is related to eating disorders, answer the following:
Current Height: _____ Current Weight: _____ Weight Loss/Gain: ☐ Loss ☐ Gain
Weight Loss/Gain in lbs: _____ lbs Weight Loss/Gain in Last Months: _____ months

What Services Are Your Requesting?*
☐ MMO – Medically Monitored Only
☐ Management & Treatment Services
☐ Injectable Track Services

Disabilities	None	Mild	Moderate	Severe	Duration of Symptoms	
Anxiety/Panic/OCD*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year
Appearance/Grooming/Dress*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year
Depression/Labile Mood*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year
Hallucinations/Delusions*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year
Inattention/Hyperactivity*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year
Manic Symptoms*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year
Marriage/Family*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year
Sleep Disturbances*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year
Social/Recreational*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year
Work/School Performance*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year
Other	☐	☐	☐	☐	☐ Less than 1 month ☐ 1-6 months	☐ 7-11 months ☐ More than 1 year

Is there co-morbid substance use?* ☐ Yes ☐ No ☐ Unsure

If yes, answer the following:

Substance: _____ Frequency: _____ Amount: _____
Substance: _____ Frequency: _____ Amount: _____
Substance: _____ Frequency: _____ Amount: _____
Substance: _____ Frequency: _____ Amount: _____

Has patient been referred to: ☐ AA ☐ CD Inpatient Treatment ☐ CD Outpatient Treatment

Is the patient currently taking any medication?* ☐ Yes ☐ No ☐ Unsure

If yes, answer the following:

Name	Dose	Frequency	Side Effects	Compliance %

Treatment Goals* (Please list the three most significant problems identified): **Estimated Completion Date***

1. _____ _____
2. _____ _____
3. _____ _____

Progress in Treatment (check one)*:

☐ Continues with/or Reoccurrence of Acute Presenting Symptoms
☐ Mild to Moderate Improvement
☐ Significant Improvement of Symptoms
☐ Needs Support/Maintenance Only
☐ Termination Phase of Treatment
☐ Other: _____

Expected Treatment Outcomes (check all that apply)*:

☐ Discharge from Active Treatment Due to Significant Improvement in Symptoms
☐ Discharge from Active Treatment, Transfer to Self-Help/Other Supports
☐ Provide Ongoing Supportive Counseling to Maintain Stabilization of Symptoms

Certification Start Date*: _____

Certification is not valid until CBA issues a certification number.