Outpatient Psychotherapy/Counseling Request Form

1. Identifying Information

Client Information

Medicaid number:			Date: / /	
Client name	Last:		First:	Middle Initial:
Date of birth: / /	Age:	Sex:	Began current treatment: / /	
Current living arrangements:	☐ With parent(s)	☐ Group/foster home	☐ Other (list):	

Provider Information

Performing provider:	Telephone:
Address:	
Medicaid Provider Identifier (ID):	NPI:
Taxonomy:	Benefit Code:

2. Current DSM IV diagnoses (list all appropriate diagnosis codes):

Axis I:				
Axis II:				
Axis III:				
Axis IV:				
Axis V [GAF*]:				
Current substance abuse?	☐ None	☐ Alcohol	☐ Drugs	☐ Alcohol and Drugs

3. Court ordered service?	☐ Yes ☐ No	Court order signed by judge must be attached.
4. DFPS directed service?	☐ Yes ☐ No	DFPS directive or summary signed by employee must be attached.
DFPS employee's name:		DFPS employee's phone number:

5. Recent primary symptoms that require additional therapy/counseling

Include date of most recent occurrence, frequency, duration, and severity:

6. History

Psychiatric inpatient treatment	☐ Yes	☐ No	Age at first admission:	
Prior substance abuse?	☐ None	☐ Alcohol	☐ Drugs	☐ Alcohol and Drugs
Significant medical disorders:				

7. Current psychiatric medications (include dose and frequency):

8. Treatment plan

Measurable short term goals, specific therapeutic interventions utilized and measurable expected outcome(s) of therapy:

9. Number of sessions requested (limit 10 per request)

List the specific procedure codes requested:

How many of each type?	IND	Group	Family
Dates	From (start of visits): / /	To (end of planned requested visits): / /	
List specific procedure codes requested:			

Provider signature: Date: / /

Provider printed name:

*GAF = Global Assessment of Functioning