PLEASE FAX TO: (812) 378-7054

Outpatient Mental Health Treatment Plan

Member ID Number:	Patient's Date of Birth:	Precert #:
Physician's Name	Facility:	Patient's ID Number
Date of Initial Evaluation:	Frequency of Therapy:	Expected Length of Treatment:

Is the Physician directly providing treatment/service:

☐ Yes ☐ No

If No, identify who is giving the care and their discipline?

_____

Please Complete all Axes using DSM-IV

I _____ II _____ III _____ IV _____ V(GAF) _____

HISTORY OF DIAGNOSIS

Presenting Complaint:

Describe background and development of current problems:

Describe mental status findings:

Describe how symptoms impair functions (social, work, family)(for children, describe school function)

Substance abuse (how much and how often does it Impair Function?):

PAST HISTORY

Describe past psychiatric or substance abuse history:

Describe past medical history:

Have any family member (identify whom):

-Been treated for psychiatric problems or substance abuse?

-Attempted or committed suicide?

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MEDICATIONS What medications are currently being used? What Psychotropic medications have been used in the past?		**SUPPORT SYSTEMS** Describe present support systems:	
Problem Area	Discharge Criteria (Goals to be accomplished)	Psychotherapeutic Modalities	Time Frame (Frequency)

I verify my involvement in the treatment o f this client, and agree to supervise all modifications to this treatment plan on a regular basis.

Physician's Signature: _____ Date: _____

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