Outpatient Review Form

Please Fax to Carelon Behavioral Health:
855.371.9227 / 781.994.7111

Member information *(Verify eligibility before rendering services)*

Member name:________________________ **Member ID#:**________________ **D.O.B:** ______________

Provider information

Provider / agency name: ______________________ **Clinician name:** ______________________

Provider ID#: ______________________ **Phone number:** ______________________

Request for sessions

I request_______sessions, starting on:____________________over the next: ○ **90 days** ○ **180 days** ○ **Other:** ______________

Current psychotropic medications

Are psychotropic meds being prescribed? ○ Yes* ○ No ○ Unknown *If Yes, prescribed by: ○ MD ○ RN ○ CS/NP ○ PCP

Prescriber:__________________________ **List Meds:** __________________________

Have you communicated with the member's prescriber of psychotropic drugs?

○ Yes ○ No ○ Member declined ○ N/A; Member not on medications ○ N/A; Provider is the prescriber

Have you communicated with member's PCP? ○ Yes ○ No ○ Member declined

Have you documented the communication or member declination? ○ Yes ○ No ○ N/A; I did not contact PCP

Have you been in communication with other BH providers for this member?

○ Yes *(please specify)*:______________________ ○ No ○ Member declined ○ N/A; There are no other BH providers

Site of treatment

○ Office ○ Home ○ School ○ Other *(please specify)*: ______________________

Additional Comments: ______________________

ICD 10/DSM 5 diagnoses *(Please give more than one diagnosis as necessary for clinical presentation.)*

Diagnosis:______________ Diagnosis:______________ Diagnosis: ______________ Diagnosis: ______________

Current risk indicators *(check all that apply)*:

☐ Current substance abuse ☐ Caring for ill family member ☐ Self-mutilating / cutting ☐ Sexually offending behavior

☐ Current family violence ☐ Fire setting ☐ Impulsive behavior ☐ Assaultive behavior ☐ Psychotic symptoms

☐ Coping with significant loss ☐ Prior Psychiatric Inpt. Admission ☐ Other *(please specify)*: ______________

Status of 3 most significant objectives since treatment initiation *(Please include additional page if space provided is insufficient.)*

Objectives *(in measureable/behavioral detail)*	**Modality** *(Individual/Group)*	**Progress** *(Rating since Tx began; use scale below)*
1.		
2.		
3.		

N = New Goal 1 = Much Worse 2 = Somewhat Worse 3 = No Change 4 = Slight Improvement 5 = Much Improvement R = Resolved

Risk assessment *(Check all that apply)*

Suicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt *(please specify date)*: ______________

Homicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt *(please specify date)*: ______________

Rate member's level of psychological distress: ○ 1 *(minimal)* ○ 2 *(mild)* ○ 3* *(moderate)* ○ 4* *(marked)* ○ 5* *(severe)*

Current risk of psychiatric hospitalization*: ○ 1 *(minimal)* ○ 2 *(mild)* ○ 3* *(moderate)* ○ 4* *(marked)* ○ 5* *(severe)*

***If 3 or higher, have you created/reviewed a crisis plan for this member?** ○ Yes* ○ No ○ ***If yes does member have a copy?** ○ Yes ○ No

Has the member been in higher level of care in the last 12 months? ○ Yes ○ No Member declined

Was a standard instrument used to evaluate treatment progress? ○ Yes* ○ No ***If yes, name instrument(s): __________________________________**