

Outpatient Treatment Report

PLEASE FILL OUT ALL APPLICABLE AREAS

Patient's Name:		Clinician:	
ID Card #:		Phone:	
DOB:		Fax:	
Date Of Initial Visit:		Service Location	
Individual NPI:		Address:	
		City & State:	
		Group NPI:	

Treatment History (check all that apply)	PSYCH	CD
None:	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient:	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient:	<input type="checkbox"/>	<input type="checkbox"/>
Last 90 Days	<input type="checkbox"/>	<input type="checkbox"/>
Last 12 Months	<input type="checkbox"/>	<input type="checkbox"/>
>12 Months	<input type="checkbox"/>	<input type="checkbox"/>
1 prior admit	<input type="checkbox"/>	<input type="checkbox"/>
>2 prior admits	<input type="checkbox"/>	<input type="checkbox"/>

Functional Disabilities (circle and rate all that apply)				
	NONE	MILD	MODERATE	SEVERE
Marriage/Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social/Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appearance/Grooming/Dress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work/School Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations/Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Self/Other Harm Passive Thoughts Plan Intent Comments: _____

Appetite: Current Ht ____ Wt ____ lbs ▶ Weight Loss ____ lbs Weight Gain ____ lbs In last ____ Months

Sleep Disorder: Total Hours/Night ____ Problems: Falling Asleep Staying Asleep Waking Up On Time

Symptoms Have Been Present for: Less Than 1 Month 1-6 Months 7-11 Months More Than a Year

Current Medication	Name	Dose	Frequency	Side Effects
<input type="checkbox"/> New	1. _____	_____	_____	_____
<input type="checkbox"/> New	2. _____	_____	_____	_____
<input type="checkbox"/> New	3. _____	_____	_____	_____
<input type="checkbox"/> New	4. _____	_____	_____	_____

Compliance >90% 50-90% <50%

Reasons for Noncompliance: _____

Diagnosis

Axis I: _____ Axis V: Initial GAF: _____
 _____ Current GAF: _____

Axis II: _____ Start of Certification: _____

Axis III: _____ Last Office Visit: _____
 _____ When do you want this certification to start? _____

Axis IV: _____

CPT	Frequency	CPT	Frequency
90804 <input type="checkbox"/>		90847 <input type="checkbox"/>	
90805 <input type="checkbox"/>		90853 <input type="checkbox"/>	
90806 <input type="checkbox"/>		90862 <input type="checkbox"/>	
90807 <input type="checkbox"/>		Other <input type="checkbox"/>	
90846 <input type="checkbox"/>		Other <input type="checkbox"/>	

Clinician's Signature: _____ Date: _____

****We strongly recommend contacting the prescribing or referring physician.

Date of Contact: _____ Method of Contact: Telephone Fax Progress Note

Additional Clinical Information/Progress Since Last Update: _____

*****Return to Confidential Fax Line 803-714-6456*****