Blue Cross and Blue Shield of New Mexico

OUTPATIENT TREATMENT REPORT

Blue Cross Blue Shield of New Mexico 1-800-325-8334 opt 4 ext 2082
Fax #: 505-816-2603

Check One: **Initial Outpatient Treatment Report** **Continuing Outpatient Treatment Report**

DEMOGRAPHICS

Patient's Name ____________________________________

Subscriber Name ____________________________ Subscriber ID# _______________________

Patient Date of Birth ________/_________/_______Age _______ Gender ________________
Patient Phone # Home ____________________ Work ______________________

Primary Insurance Plan ____________________________________
Secondary Insurance Plan ____

Name of Practitioner / Tax ID# ____
Practitioner's Address ____
City____________________________________ State____________________ Zip____________
Telephone Number __________________________________ Fax #: ______________________

DSM IV DIAGNOSIS CODES

Axis I: / __/ __/ __ • / __/ __/ / __/ __/ __/ • / __/ __/ / __/ __/ __/ • / __/ __/
Axis II: / __/ __/ __ • / __/ __/ / __/ __/ __/ • / __/ __/ / __/ __/ __/ • / __/ __/

Axis III: ____
Axis IV: ____
Axis V: Current____ ___ Highest in last year____ ___ Expected GAF at discharge____ ___
(Document specific GAF score – not range)

91-100	Superior function	81-90	Minimal symptoms	71-80	Mild/transient symptoms
61-70	Mild symptoms	51-60	Moderate symptoms	41-50	Serious symptoms
31-40	Impaired Reality Testing	21-30	Inability to function	11-20	Some danger
01-10	Serious danger of hurting self or others				

Are you independently licensed? Yes No

Discipline, State License and Number ____

ASSESSMENT

Previous Treatment *(Please check all that apply).*

Psychiatric	Substance Abuse	Treatment Outcomes:
None	None	_________________________
Outpatient	Outpatient	_________________________
Inpatient	Inpatient	_________________________
Within last 12 months	Within last 12 months	_________________________
2 or more prior admissions	2 or more prior admission	_________________________

Symptoms *(Please check all that apply. Those not checked will be assumed absent.)*

Depressed Mood	Hyperactivity	Emotional/Physical/Sexual Trauma Victim
Decreased Energy	Disruption of Thought Process/Content	Emotional/Physical/Sexual Trauma Perpetrator
Grief	Delusions	Substance Use (check one)
Hopelessness	Hallucinations	Active Substance Abuse
Worthlessness	Paranoia	Early Full Remission
Guilt	Dissociative State	Early Partial Remission
Anxiety	Oppositionalism	Sustained Full Remission
Panic Attacks	Somatic Complaints	Sustained Partial Remission
Obsessions/Compulsions	Concomitant Medical Condition	Other (specify)__________
Elevated Mood	Impulsiveness	Other (specify) _________
Irritability		

Symptoms have been present: Less then 1 month 1-6 months 7-11 months More than a year

Functioning *(Please assess how current symptoms have affected the level of impairment in the following categories)*

Categories	Impairment Level (Circle level)		
	Mild	**Moderate**	**Severe**
Relationships	1	2	3
Job/School Performance	1	2	3
Stressors	1	2	3
Anger/Behavior	1	2	3
Physical Health	1	2	3
Activities of Daily Living (personal Hygiene, bathing etc.)	1	2	3
Eating Habits	1	2	3

Weight Loss ________lbs. Weight Gain ________lbs. Height ______________

Sleeping Habits	1	2	3

Difficulty Falling Asleep Difficulty Staying Asleep Early Morning Awakening

Risk Assessment *(Check all that apply)*

Suicidality:	Not present	Ideation	Plan	Means	Prior Attempt	Date __________
Homicidiality:	Not present	Ideation	Plan	Means	Prior Attempt	Date __________

Other risk behaviors :____
____
____

TREATMENT PLAN

Patient's Name____

Primary treatment approach *(Check one)*

Problem focused   Symptom Focused   Complex Case
Therapeutic Stabilization   Medication Management Only

Progress in Treatment *(Check one)*

Continues with/or recurrence of acute presenting symptoms
Needs support/maintenance only
Somewhat improved   Near completion of treatment
Much improved   Other: ________________________________

Expected Treatment Outcomes *(Check all that apply)*

Reduction in symptoms and discharge from active treatment
Return to highest GAF and discharge from active treatment
Transfer to self help/other supports and discharge from active treatment
Provide ongoing supportive counseling and maintain stabilization of symptoms
Provide ongoing medication management

Did Patient concur with goals and strategies of treatment plan?   Yes   No

Medication *(list all psychotropic and other medications if applicable)*

Has patient been evaluated for medication?   Yes   No

Current MEDICATION: None   Psychotropic   Medical Other ____________

Does patient follow medication regime?   Yes   No

Prescribing physician (indicate if PCP or Psychiatrist):________________________________

Name of Medication	Current Dosage/Frequency	Start Date	Side Effects
			Yes No
			Yes No
			Yes No
			Yes No

Describe side effects/interventions:____

____

Clinical Formulation/ Other comments

Use specific behavioral descriptors to address additional clinical information that impacts treatment (e.g. progression of symptoms, text results/lab values, pertinent history, concomitant issues, factors impeding progress, effectiveness of current strategies).

____
____
____

Clinical Formulation/Other Comments *(continued)*

____
____
____
____
____
____
____

Treatment Frequency & Duration

Date First Seen ______________________ Date First Seen This Yr____________________

Total Number of Visits Used This Yr .___________________________

Estimated Total Visits Needed This Yr. ___________________________

# of Visits requested at this time_______________ Date Last Seen_____________________

	Frequency (i.e., 1x/wk., 1x/mo., etc.)	Estimated Discharge Date
Psychotherapy (45-50 min) 90806		
Group Therapy (60-90 min) 90853		
Other		
Other		

What other treatment or community services is the patient receiving?

None   Individual   Group   EAP   Medication Management
Family   AA/NA   Structured Program   Other

Medical Treatment (Date of Last Physical Examination) ____________________________

Last date of contact to coordinate treatment: Behavioral ____________   Medical __________

Are other family members in treatment?   Yes   No   With You?   Yes   No

Treating Provider's Signature:____   **Date:** ____

For Blue Cross Blue Shield of New Mexico Use Only

MHSA Professional Reviewer:____Dates of Authorization: _______________________ to __________________________

Authorization Number: ____________________________________ Eligibility Verified: Date Authorized: _______________ Input/Tech: ________________________________

Approved: Approved with Modification: Denied: Reason: ____ Medical Director: __________________________