

Network Health Plan Outpatient Treatment Report for Behavioral Health

To request additional treatment sessions, please complete and fax this form to NHP at (920) 720-1903.
Address: Behavioral Health Care Management Department Network Health Plan 1570 Midway Place Menasha, WI.54952
Provider questions: (920) 720- 1340 or (800) 555-3616

Client Name: _____
Date of Birth: _____
Member #: _____
Therapist name: _____
Requesting ____ (1-6) additional sessions

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
GAF: _____

Current Symptoms: (within the last five sessions): _____

Level of symptoms? (place an "x" to indicate symptoms @ start of treatment, "0" for current level of symptoms)

0 _____ 50 _____ 100
problematic _____ controlled

For the following, check all that apply from the previous five sessions:

Behavior/Symptoms:

- Suicidal/Homicidal Ideation
- Active substance use
- Psychotropic medication(s) prescribed
- Compliant with medication regime
- Unwilling/Unable to follow prescribed med regime
- Comorbid medical condition
- Weight loss/lack of weight gain
- Disordered eating
- Self-mutilation improved/controlled
- Irritability/hostility improved
- Agitated/Impulsive behavior improving

Impact on Functioning:

- Decrease in social contacts
- Decrease in ability to care for self
- Decrease in care to dependent children/elders
- School/Work: verbal/written warning
- absent >1 day/month
- decrease productivity
- detentions suspensions
- not a student/not employed
- LOA due to psych condition
- Relationships: Conflictual/hostile
- Occasional arguments

Attendance:

#Appointments scheduled: _____
#Appointments attended: _____

Service Provided:

Individual Group Family
Session frequency: _____

Support :

- Involved in Community support group
- Family/friends involved, supportive

Client level of engagement with Treatment:

- Good Acceptable Poor None

Any additional information: _____

Treatment Plan: Current, measurable treatment goals:

1. _____
2. _____

Changes necessary before termination of treatment: _____

Coordination of Care:

- Release of Information signed for communication with PCP
- Regular exchange of information occurs between PCP and therapist
- Member refuses to sign Release of Information

Signature: _____

153 Tele: _____

Date: _____