carelon

OUTPATIENT REVIEW FORM

Requested Start Date ___ / ___ / _____

NOTE: This form cannot be used to request ECT or psychological testing.

Type of Service Requested: ☐ Mental Health ☐ Substance Abuse

Patient Name: _____
Date of Birth: _____ Age: _____
Street Address : _____
City/State/Zip: _____
Tel #:_____ Patient's Insurance ID#:_____
Patient's Employer/Benefit Plan: _____

Provider Name: _____ License: _____
Name of Program/Clinic (if applicable): _____
Carelon Provider ID# (if known):_____ Tel# _____
Provider Email Address:_____
Service Address: _____
City/State/Zip: _____
Is this also your mailing address? ☐ Yes ☐ No *If no, please update below signature.*

Are you independently licensed to provide services in the State where you are treating this patient? ☐ Yes ☐ No
ID#: _____ Check Which: ☐ SSN ☐ Tax ID ☐ NPI

Diagnosis:
Behavioral DX (ICD Code & Description): 1. _____ /_____
2. _____/_____
Medical DX (ICD code & category: 1. _____ /_____
2. _____/_____
Social Elements Impacting DX: 1. _____ 2. _____
Optional Functional Assessment: Tool: _____ Score: _____
Additional Info: _____

Treatment History: (please select all that apply)
Previous Treatment in the Past 12 Months, excluding current course of treatment:
Type: ☐ Mental Health ☐ Substance Abuse ☐ Both ☐ None ☐ Unknown ☐ Outpatient ☐ Partial/IOP ☐ Inpatient ☐ Residential ☐ Group Home ☐ Other

Outcome: ☐ Unknown ☐ Improved ☐ No Change ☐ Worse

Treatment Compliance (Non-Med): ☐ Unknown ☐ Poor ☐ Fair ☐ Good

Is the individual currently receiving disability benefits ☐ Yes ☐ No

Current Risk Assessment: (Please select/circle one value for each type of risk Key: 0 = none; 1 = mild, ideation only; 2 = moderate, ideation with EITHER plan or history of attempts; 3 = severe, ideation AND plan, with either intent or means; na = not assessed)

Patient's risk to others: 0 1 2 3 na

Patient's risk to self: 0 1 2 3 na

Current Impairments: (Please select/circle one value for each type of impairment)
Scale: 0=none 1 =mild/mildly incapacitating 2=moderate/moderately incapacitating 3 =severe or severely incapacitating na=not assessed

Mood Disturbance (Depression or Mania)	0 1 2 3 na
Anxiety	0 1 2 3 na
Psychosis/Hallucinations/Delusions	0 1 2 3 na
Thinking/Cognition/Memory/Concentration Problems	0 1 2 3 na
Impulsive/Reckless/Aggressive Behavior	0 1 2 3 na
Activities of Daily Living Problems	0 1 2 3 na
Weight Change Associated with a Behavioral Diagnosis Select One: ☐Gain ☐Loss ☐na of ___ lbs. in last three months Current weight= ____ lbs. ☐ na Height= ____ ft. ___ inches	0 1 2 3 na
Medical/Physical Condition	0 1 2 3 na
Substance Abuse/Dependence Select all that apply: ☐Alcohol ☐Illegal Drugs ☐Prescription Drugs	0 1 2 3 na
Job/School Performance Problems	0 1 2 3 na
Social/Relationship/Marital/Family Problems	0 1 2 3 na
Legal Problems	0 1 2 3 na
Additional comments describing clinical need (if applicable):	

Treatment Plan: Reason for continued treatment (please select primary reason)
☐Remains symptomatic ☐Prepare for discharge within coming month ☐ Maintenance ☐ Facilitate return to work

Please indicate type(s) of service provided BY YOU, and the frequency.

☐ Medication Management (enter code requested) _____ ☐Wkly ☐Monthly ☐Qtrly ☐Other
☐ lndiv. Psychotherapy (30 min) 90832 ☐Wkly ☐Monthly ☐Qtrly ☐Other
☐ lndiv. Psychotherapy (45 min) 90834 ☐Wkly ☐Monthly ☐Qtrly ☐Other
☐ Family Psychotherapy (45-50 min) 90847 ☐Wkly ☐Monthly ☐Qtrly ☐Other
☐ Group Therapy (60-90 min) 90853 ☐Wkly ☐Monthly ☐Qtrly ☐Other
☐ Other_____ ☐Wkly ☐Monthly ☐Qtrly ☐Other
☐ Other_____ ☐Wkly ☐Monthly ☐Qtrly ☐Other

Please complete both sides of form

Please indicate type(s) of service provided BY OTHERS (select all that apply):

☐ Medication Management ☐ lndiv. Psychotherapy ☐ Family Psychotherapy ☐ Group Therapy ☐ CommunityProgram(s) ☐ Self Help Group(s)

Are the Patient's family/supports involved in treatment? ☐ Yes ☐ No

Has Patient been evaluated by a psychiatrist: ☐ Yes ☐ No

Current Psychotropic Medications: Dosage, Frequency, Usually adherent?

1._____ ☐ YES ☐ NO
2._____ ☐ YES ☐ NO
3._____ ☐ YES ☐ NO

Treating Provider's Signature: _____ Date: _____
Updated Mailing Address: _____
City/State/Zip: _____

Carelon Behavioral Health Providers are expected to endorse their use of Clinical Practice Guidelines based interventions as part of their treatment with this member. This applies to all Behavioral Health conditions and includes additional interventions for Diagnosis Specific conditions /populations as appropriate. This information is required as part of the review process. Please complete both sides of this page as applicable.

The patient's chart reflects that:

1. I am treating this patient according to Carelon treatment guidelines. ☐ Y ☐ N ☐ NA
2. I am coordinating this patient's case with other providers as appropriate. • Behavioral: ☐ Y ☐ N ☐ NA • Medical: ☐ Y ☐ N ☐ NA
3. The treatment plan was developed with the patient and has measurable, time limited goals. ☐ Y ☐ N ☐ NA

GUIDELINE BASED INTERVENTIONS FOR ALL BEHAVIORAL HEALTH CONDITIONS

☐ Co-occurring medical conditions have been assessed and addressed, if applicable in treatment plan

☐ For primary psychiatric disorders, co-occurring substance use conditions have been assessed and addressed, if applicable, in treatment plan

☐ For primary substance abuse disorders, co-occurring psychiatric conditions have been assessed and addressed, if applicable, in treatment plan

☐ For conditions where Evidence Based Practice guidelines recommend pharmacological treatment, appropriate options have been evaluated and/or prescribed by the member's PCP/Psychiatrist.

☐ Treatment process includes one or more evidenced based psychosocial treatment modalities:

- ☐ Cognitive behavioral therapies including social skills training, destabilization prevention, relapse prevention, standard cognitive therapy
- ☐ Motivational Enhancement therapy
- ☐ Illness management skills
- ☐ Family interventions/ therapy as indicated
- ☐ Community based self-help organizations and peer support groups

Please complete both sides of form

☐ Clinical impairment rating and treatment plan reflects either improvement in symptoms within 90 days of treatment onset, or, if not, patient's condition has been re-evaluated and adjustments in treatment plan made accordingly

☐ Risk issues have been assessed and addressed in treatment plan and addressed in treatment plan and are continually monitored during treatment.

DIAGNOSIS SPECIFIC ADDITIONAL GUIDELINE BASED INTERVENTIONS complete as indicated for the following diagnosis specific conditions/populations:

Alcohol related disorders

☐ To promote abstinence and prevent relapse, Pharmacotherapy options have been presented to member including:

- ☐ Acamprosate (Campral)
- ☐ Disulfiram (Antabuse)
- ☐ Oral Naltrexone (Re Via, Depade)
- ☐ Extended-release injectable naltrexone (Vivitrol)

☐ Relapse contingency planning is incorporated in treatment process

☐ Aftercare support is incorporated in the treatment process D

Child and Adolescent

☐ Available ancillary and/or supportive services have been evaluated and are utilized as needed

Cognitive disorders

☐ Caregivers are encouraged to seek support, if applicable, including education programs, respite care and support groups

☐ The use of pharmacologic treatment for cognitive impairment has been discussed with the member or their proxy

☐ Medical explanations have been considered/ruled out in reaching this diagnosis

Eating Disorder:

☐ Treatment plan includes monitoring and documentation of target weight and rate of progress.

☐ Patient is receiving nutritional counseling by a trained provider.

Psychotic Disorders:

☐ The treatment plan continues to reinforce adherence with psychopharmacological interventions.