

Phone: 800-868-1032



*Required information

Extended Outpatient Mental Health Treatment Request

Clinician's First Name*:							
Licensure*:	Clinician's First Name*:				Clinician's	Last Name:	
Fax*	Licensure*:						
Mailing Address 2:							
State* ZIP Code*:							
Patient's First Name*:					State*	7IP	Code*:
Patient's First Name':							
Date of Birth*:	Chilician S 141 1 .				Group IVI I.		
Date of Birth*:	Patient's First Name*:				Patient's La	ast Name*:	
Phone:							
Diagnosis Axis V: Initial GAF*: Current GAF*: Please check all that apply*: Thoughts of passively dying Axis II: Axis IV: Last Office Visit*: Please check all that apply*: Thoughts of passively dying Active thoughts Endorses intent Endorses intent Endorses plan If diagnosis is related to eating disorders, answer the following: Weight Loss/Gain: Loss Gain More than 1 year If diagnosis is related to eating disorders, answer the following: Weight Loss/Gain: Loss Gain More than 1 year If diagnosis is related to eating disorders, answer the following: Weight Loss/Gain: Loss Gain More than 1 year If diagnosis is related to eating disorders, answer the following: Weight Loss/Gain: Loss Gain More than 1 year If diagnosis is related to eating disorders, answer the following: Weight Loss/Gain: Loss Gain More than 1 year If diagnosis is related to eating disorders, answer the following: Weight Loss/Gain: Loss Gain More than 1 year If diagnosis is related to eating disorders, answer the following: Weight Loss/Gain: Loss Gain More than 1 year If diagnosis is related to eating disorders, answer the following: Weight Loss/Gain: Loss Gain More than 1 year In a thought Loss/Gain: Loss Duration of Symptoms More than 1 year In a thought Loss/Gain: Loss than 1 month 7-11 months More than 1 year In a thought Loss/Gain: Less than 1 month 7-11 months More than 1 year In a thought Loss/Gain: Less than 1 month 7-11 months More than 1 year In a thought Loss/Gain: Loss than 1 month 1-6 months More than 1 year In a thought Loss/Gain: Less than 1 month 1-6 months More than 1 year In a thought Loss/Gain: Less than 1 month 1-6 months More than 1 year In a thought Loss/Gain: Less than 1 month 1-6 months More than 1 year In a thought Loss/Gain: Less than 1 month 1-6 months More than 1 year In a thought Loss/Gain: Less than 1 month 1-6 months							
Axis I*:							
Axis I*:	Diagnosis				Harm Is	sues*· 🗆 None 🗀 S	Self Others
Axis II:	A . 14	s V: Initial	GAF*:			Sucs: None	
Axis II:		Curre	nt GAF*:		Please o	check all that apply*:	
Axis III:	Axis II:				☐ Thou	ughts of passively dying	
Endorses plan	Avia III:						
If diagnosis is related to eating disorders, answer the following: Current Height: Weight Loss/Gain: Ibs Weight Loss/Gain occurred in last Months Impairments None Mild Moderate Severe Duration of Symptoms Anxiety/Panic/OCD* Less than 1 month 7-11 months More than 1 year Appearance/Grooming/Dress* Depression/Labile Mood* Depression/Labile Mood* Hallucinations/Delusions* Manic Symptoms* Manic Symptoms* Manic Symptoms* Marriage/Family* Seep Disturbances* Meight Loss/Gain: Weight Loss/Gain: Weight Loss/Gain: Weight Loss/Gain: Less than 1 month 7-11 months More than 1 year Less than 1 month 1-6 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 1-6 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year Less than 1 month 7-11 months More than 1 year	Axis IV: Last	Office Visi	t*:		1 I 		
Current Height:						orses plan	
Current Height:							
Current Height:	If diagnosis is related to eating	disorders :	answer tl	he following:			
Impairments None Mild Moderate Severe Duration of Symptoms Anxiety/Panic/OCD*					We	eight Loss/Gain: 🔲 Loss	□ Gain
Impairments None Mild Moderate Severe Duration of Symptoms Anxiety/Panic/OCD*	Weight Loss/Gain:	lbs	W	eight Loss/G	ain occurred	in last mo	onths
Anxiety/Panic/OCD*							
Anxiety/Panic/OCD*	Impairments	None	Mild	Moderate	Severe		• •
Appearance/Grooming/Dress*	Anviety/Panic/OCD*					Less than 1 month	☐ 7–11 months
Appearance/Grooming/Dress*	Anxiety/i anie/eeb	Ш	Ш			1–6 months	☐ More than 1 year
Depression/Labile Mood*	Anna ann an (Cura min a / Duana *					Less than 1 month	☐ 7–11 months
Hallucinations/Delusions*	Appearance/Grooming/Dress*		Ш	Ш	Ш	1–6 months	☐ More than 1 year
Hallucinations/Delusions*						□ Less than 1 month	7–11 months
Hallucinations/Delusions*	Depression/Labile Mood*			Ш			
Inattention/Hyperactivity* In							<u>*</u>
Inattention/Hyperactivity* In	Hallucinations/Delusions*						
Inattention/Hyperactivity*						1–6 months	
Manic Symptoms*	Inattention/Hyperactivity*	П	П				☐ 7–11 months
Manic Symptoms*	matterner, ryperaenvity					☐ 1–6 months	☐ More than 1 year
Marriage/Family* Sleep Disturbances* Social/Recreational* Less than 1 month	Maria O matamat					Less than 1 month	☐ 7–11 months
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Marriage/Family* Sleep Disturbances* Social/Recreational* Sometic Complaints* More than 1 year Less than 1 month 1–6 months More than 1 year Less than 1 month 7–11 months More than 1 year Less than 1 month 1–6 months More than 1 year Less than 1 month 7–11 months More than 1 year						□ Less than 1 month	· · · · · · · · · · · · · · · · · · ·
Sleep Disturbances*	Marriage/Family*					=	—
Social/Recreational*							
Social/Recreational* Complaints* Complaints* More than 1 year	Sleep Disturbances*						
Social/Recreational*	·					∐ 1−o montns	
Sometic Complaints*	Social/Recreational*						☐ 7–11 months
Somatic Complaints*	Journ Necreational	Ш	Ш	Ш	Ц	1–6 months	☐ More than 1 year
Somatic Complaints*	0					Less than 1 month	7–11 months
	Somatic Complaints*	Ш		\Box	\Box		



ork/School Performa	ance*				-11 months ore than 1 year
ther	[<u> </u>	911 months ore than 1 year
there co-morbid su yes, answer the follow obstance: obstance: obstance:	wing:	Freq	No Unsur	Amount: _ Amount: _ Amount: _	
as patient been referi	red to: AA	CD II	npatient Treatment	☐ CD Outpatient Treatment	
the patient currentlyes, answer the follow	wing:	medication?* [☐ Yes ☐ No	☐ Unsure Side Effects	Compliance %
easons for non-comp	liance:				
Treatment	oliance:	Substance Use Disorder		ecent Treatment	
Treatment		Substance			hs
Treatment History		Substance	R€	ecent Treatment Last 12 months	
Treatment History Inpatient		Substance	Re Last 90 Days Last six months Last 90 Days	ecent Treatment Last 12 months More than prior 12 mont Last 12 months	hs
Treatment History Inpatient		Substance	Last 90 Days Last six months Last 90 Days Last six months Last six months Last 90 Days	Last 12 months More than prior 12 mont Last 12 months More than prior 12 mont Last 12 months More than prior 12 mont	hs hs
Treatment History Inpatient RTC		Substance	Last 90 Days Last six months Last 90 Days Last six months Last six months Last 90 Days Last six months Last 90 Days Last six months	Last 12 months More than prior 12 mont Last 12 months Last 12 months More than prior 12 mont Last 12 months More than prior 12 mont Last 12 months More than prior 12 mont	hs hs
Treatment History Inpatient RTC IOP Partial Outpatient	Psychiatric	Substance	Last 90 Days Last six months	Last 12 months More than prior 12 mont Last 12 months Last 12 months More than prior 12 mont Last 12 months More than prior 12 mont Last 12 months More than prior 12 mont Last 12 months Last 12 months Last 12 months Last 12 months	hs hs
Treatment History Inpatient RTC IOP Partial Outpatient detime Admissions: [Psychiatric	Substance Use Disorder	Last 90 Days Last six months	Last 12 months More than prior 12 mont	hs hs

Companion BENEFIT ALTERNATIVES



Phone: 800-868-1032 Fax: 803-714-6456

www.CompanionBenefitAlternatives.com

Progress in Treatment*:							
☐ Continues with/or Reoccurre		g Symptoms					
Mild to Moderate Improvem							
Significant Improvement of							
☐ Needs Support/Maintenance							
Termination Phase of Treat							
Expected Treatment Outcome							
Discharge from Active Trea							
Discharge from Active TreaProvide Ongoing Supportive							
Provide Origonia Supportive	3 Couriseiing to Maintair	i Stabilization of Symptoms					
List the requested procedure	codes*: Please indicat	te frequency of time frame	e for each requested CPT code.				
CPT Code:	Frequency:	time(s) per □ week	month				
CPT Code:							
CPT Code:			month				
	_	_					
If requesting CPT code 90847,		rriage therapy or 🔲 family t	herapy?				
If requesting CPT code 90853,	list group's name;						
Certification Start Date*:							
Have you contacted the prescri	bing and/or referring phy	/sician? ☐ Yes ☐ N	No				
	zg aa. e e.eg p,	,					
Additional Clinical Information/P	rogress Since Last Upd	ate:					

Certification is not valid until CBA issues a certification number.