Companion
BENEFIT ALTERNATIVES

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SC DMH Continued Outpatient Mental Health Treatment Request Form
(South Carolina Department of Mental Health Clinic ONLY)

NOTE: CBA will not accept referrals for psychological testing on this form. Please use the CBA Psychological Testing Pre-Authorization Request Form.

**Required information*

Clinic's Name*: _____ Phone*: _____

Mailing Address 1*: _____ Fax*: _____

Mailing Address 2: _____ E-mail*: _____

City*: _____ State*: _____ ZIP Code*: _____

Clinic's NPI*: _____

Contact's First Name: _____ Contact's Last Name: _____

Contact's Extension*: _____

Patient's First Name*: _____ **Patient's Last Name***: _____

Date of Birth*: _____ **ID Card Number*:** _____

Phone: _____ **E-mail**: _____

Patient's CIN: _____

Diagnosis
Axis I*: _____ Axis V: Initial GAF*: _____
_____ Current GAF*: _____
Axis II: _____
Axis III: _____
Axis IV: _____ Treatment Start Date*:
_____ _____

Harm Issues*: ☐ None ☐ Self ☐ Others

Please check all that apply*:
- ☐ Thoughts of passively dying
- ☐ Active thoughts
- ☐ Endorses intent
- ☐ Endorses plan

If diagnosis is related to eating disorders, answer the following:
Current Height: _____ Current Weight: _____ Weight Loss/Gain: ☐ Loss ☐ Gain
Weight Loss/Gain: _____ lbs Weight Loss/Gain occurred in last _____ months

What Services Are Your Requesting?*
- ☐ MMO – Medically Monitored Only
- ☐ Management & Treatment Services
- ☐ Injectable Track Services

Impairments	None	Mild	Moderate	Severe	Duration of Symptoms	
Anxiety/Panic/OCD*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Appearance/Grooming/Dress*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Depression/Labile Mood*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Hallucinations/Delusions*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Inattention/Hyperactivity*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Manic Symptoms*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Marriage/Family*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Sleep Disturbances*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Social/Recreational*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Work/School Performance*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Other	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year

Is there co-morbid substance use?* ☐ Yes ☐ No ☐ Unsure

If yes, answer the following:

Substance: _____ Frequency: _____ Amount: _____
Substance: _____ Frequency: _____ Amount: _____
Substance: _____ Frequency: _____ Amount: _____
Substance: _____ Frequency: _____ Amount: _____

Has patient been referred to: ☐ AA ☐ CD Inpatient Treatment ☐ CD Outpatient Treatment

Is the patient currently taking any medication?* ☐ Yes ☐ No ☐ Unsure

If yes, answer the following:

Name	Dose	Frequency	Side Effects	Compliance %

Treatment Goals* (Please list the three most significant problems identified): **Estimated Completion Date***

1. _____ _____
2. _____ _____
3. _____ _____

Progress in Treatment (check one)*:

☐ Continues with/or Reoccurrence of Acute Presenting Symptoms
☐ Mild to Moderate Improvement
☐ Significant Improvement of Symptoms
☐ Needs Support/Maintenance Only
☐ Termination Phase of Treatment
☐ Other: _____

Expected Treatment Outcomes (check all that apply)*:

☐ Discharge from Active Treatment Due to Significant Improvement in Symptoms
☐ Discharge from Active Treatment, Transfer to Self-Help/Other Supports
☐ Provide Ongoing Supportive Counseling to Maintain Stabilization of Symptoms

Certification Start Date*: _____

Certification is not valid until CBA issues a certification number.