BlueCross BlueShield
Federal Employee Program

TREATMENT PLAN

Fax Number: 1-205-220-0942
Precertification Number: 1-877-722-6084

PATIENT DEMOGRAPHICS

Date:_____Was Patient Seen Today? _____Yes _____No Previous Date Patient Seen:_____

Contract Number:_____ Group Number:_____

Patient's Name:_____ DOB:_____

Address:_____State:_____ZIP:_____

PROVIDER INFORMATOIN

Provider's Name (Licensure):_____

Address:_____State:_____ZIP_____

Telephone #:_____Fax #:_____Tax ID #:_____

Date Provider Wishes Authorization to Start:_____Diagnosis:_____

Number of visits requested:_____

RISK ASSESSMENT/PATIENT CLINICAL INFORMATION

SUICIDE: _____ Not Present_____ Ideation_____ Plan_____ Means_____ Prior Attempt

No Harm Contract: _____Yes _____No **Date of Last Ideation/attempt:**_____

HOMICIDE: _____ Not Present_____ Ideation_____ Plan_____ Means_____ Prior Attempt

No Harm Contract: _____Yes _____No **Date of Last Ideation/attempt:**_____

Mood Disturbances: _____ Depression_____ Mania_____ Hypomania_____ Anxiety **Onset:**_____

Behavioral Disturbances: _____Recklessness_____ Impulsiveness_____ Decline in functioning **Onset:**_____

Eating Disorder Onset:_____ **Dementia Onset:**_____

Substance Abuse Onset:_____ **Other (please give brief description):**_____

Hallucinations: _____ Auditory_____ Visual_____ Command **Onset:**_____

_____ Delusions _____ Paranoia **Onset:**_____

Have symptoms affected the patient's job/school, relationships and/or legal status? YES NO

If so, describe the situation:_____

_____

MEDICATIONS

ADHD AND NARCOLEPSY

_____Adderall
_____Adderall XR
_____Concerta
_____Cylert
_____Providgal
_____Ritalin
_____Straterra

ALZHEIMER'S/DEMENTIAS

_____ Aricept
_____ Cognex
_____ Reminyl

ANTIDIPRESSANTS

_____Celexa
_____Desyrel
_____Effexor
_____Effexor XR
_____Elavil
_____Lexapro
_____Luvox
_____Paxil
_____Paxil CR
_____Prozac
_____Remeron
_____Serzone
_____Cybalta
_____Wellbutrin
_____Wellbutrin SR
_____Zoloft

ANTICONVULSANTS/MOOD STABILIZERS

_____Gabitril
_____Lamictal
_____Neurontin
_____Triliptal
_____Depakote
_____Lithium
_____Tegretol
_____Topamax

HYPNOTICS

_____ _Amytal
_____ _Halcion
_____ _Prosom
_____Restoril
_____Ambien
_____Sonata

ANTIPSYCHOTICS

_____Haldol
_____Prolixin
_____Thorazine
_____Abilify
_____Clozaril
_____Geodon
_____Risperdal
_____Seroquel
_____Zyprexa

ANXIOLYTICS

_____Ativan
_____Klonopin
_____Valium
_____Xanax
_____Atarax
_____BuSpar
_____Hydroxyzine
_____Vistaril

TREATMENT

TREATMENT/MEDICATION COMPLIANCE ISSUES (PLEASE DESCRIBE):_____

_____

_____

Individual Therapy **Group Therapy** **Family Therapy** **Medication Management** **ECT** **Substance Abuse**

Other (please describe):_____

_____

_____

Please give a brief description of treatment goals, including target dates:_____

_____

_____

Other Concerns:_____

_____

_____

Provider Signature:_____