

**IDENTIFYING DATA**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sponsor #: \_\_\_\_\_

**PROVIDER INFORMATION**

Provider Name: \_\_\_\_\_ Phone#:(\_\_\_\_\_) \_\_\_\_\_ Fax#:(\_\_\_\_\_) \_\_\_\_\_

**DSM-IV TR Diagnosis**

Axis I - \_\_\_.\_ / \_\_\_.\_ / \_\_\_.\_ Axis II - \_\_\_.\_ / \_\_\_.\_ Axis III - \_\_\_\_\_

Date first seen: \_\_\_\_\_ Date last seen: \_\_\_\_\_ Anticipated # of sessions to complete treatment: \_\_\_\_\_

**TREATMENT REPORT**

**Current Clinical Information:** ( Circle each. Scale 0=None 1=Mild 2=Moderate 3=Severe 4=Extreme )

Aggression	0 1 2 3 4	Impulsivity	0 1 2 3 4
Alcohol /Substance Use	0 1 2 3 4	Job / School Problems	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4	Mania	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Medical Illness	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Memory	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Delusions	0 1 2 3 4	Side Effects	0 1 2 3 4
Depression	0 1 2 3 4	Sleep Disturbance	0 1 2 3 4
Hallucinations	0 1 2 3 4	Weight Loss	0 1 2 3 4
		Other	_____

**Discharge Goals:**

Complete Remission       Significant Improvement       Baseline / Maintenance

**Medications:** (Optional for Non-Physicians)

**TYPE OF TREATMENT**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Behavior Modification          | <input type="checkbox"/> Gestalt                     | <input type="checkbox"/> Reality Therapy            |
| <input type="checkbox"/> Client Centered                | <input type="checkbox"/> Group Therapy               | <input type="checkbox"/> Relaxation Techniques      |
| <input type="checkbox"/> Cognitive-Behavioral           | <input type="checkbox"/> Hypnosis                    | <input type="checkbox"/> Social Skills Training     |
| <input type="checkbox"/> Dialectical Behavioral Therapy | <input type="checkbox"/> Interpersonal               | <input type="checkbox"/> Supportive                 |
| <input type="checkbox"/> Educational                    | <input type="checkbox"/> Medication Management       | <input type="checkbox"/> Systematic Desensitization |
| <input type="checkbox"/> Existential/Humanistic         | <input type="checkbox"/> Parent Training             | <input type="checkbox"/> Transactional Analysis     |
| <input type="checkbox"/> Exposure/Response Prevention   | <input type="checkbox"/> Psychodynamic Psychotherapy | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Family Therapy                 | <input type="checkbox"/> Rational Emotive            | _____   |

**REQUESTED SERVICES:**

**CPT Code:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**CPT Code:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

**Disclaimer:** Authorization indicates that ValueOptions-TRICARE has determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered.