United Behavioral Health

Outpatient Treatment Progress Report

To request further certifications, please fax or mail to: **United Behavioral Health**

CLIENT INFORMATION

Client Name:	Member ID:	Date of Birth
Client Address:	Provider Name:	Degree: _____
Client Home Phone:	Provider Address:	
Client Work Phone:	Provider Phone:	

Number of Sessions to date: _____ Frequency:_____

Date 1st Visit _____ Date Last Visit _____

Release of information for UBH signed: ☐ Yes ☐ No

Release of information for PCP signed: ☐ Yes ☐ No

☐ TX Plan or Summary sent to patient's PCP

☐ Patient/Parent/Guardian refused consent for release to PCP

☐ Patient states they have no PCP

If Child/Adolescent: Is Family Involved? ☐ Yes ☐ No

Prior Treatment – Episodes in past year: _____

MH: # of times Outpatient____Inpatient____PHP____IOP

CD: # of times Outpatient____Inpatient____PHP____IOP

Outcome: AMA discharge_____ Completed Treatment/still using_____

Completed Treatment/Sober_____Active in CD Support Group? ☐ Yes ☐ No

Current Symptoms:

Mood: ☐ Sad ☐ Elated ☐ Hopeless ☐ Low Energy ☐ Poor Concentration ☐ Angry ☐ Appropriate ☐ No Problem ☐ Other_____

Anxiety: ☐ Worry ☐ Panic ☐ Fearfulness ☐ Compulsive ☐ None ☐ Other_____

Thought: ☐ Delusions ☐ Hallucinations ☐ Disorganized Speech ☐ Obsessive ☐ Distractible ☐ No Problem ☐ Other_____

Behavior: ☐ Aggressive ☐ Truant ☐ Runaway ☐ Disorganized behavior ☐ Compulsive ☐ Hyperactive ☐ Other_____

Sleep Problems, Describe:_____ **Appetite Problems, Describe:**_____

DIAGNOSIS ★***TIP:*** Use ***DSM-IV*** Codes: include all Axes

Axis I – Primary _____ **Axis II** - _____

Secondary _____ **Axis III** - _____

Axis IV

☐ Economic problems ☐ Problems with accessing health services

☐ Housing problems ☐ Problems related to interactions with legal/criminal system

☐ Occupational problems ☐ Problems related to social environment/school

☐ Other psychosocial problems

Axis V (*GAF*) Current _____

Highest in last 12 months _____ **Target problems/Symptoms**:_____

_____

_____

RISK ASSESSMENT

Suicidality:

☐ None
☐ Ideation
☐ Plan
☐ Intent w/o means
☐ Intent with means
☐ Ideation in past yr
☐ Attempt in past yr
☐ Family/peer history of completed suicide

Homicidality:

☐ None
☐ Ideation
☐ Plan
☐ Intent w/o means
☐ Intent with means
☐ Ideation in past yr

Hx Substance

Abuse/Dependence:

Assessed? ☐ Yes ☐ No

Problem? ☐ Yes ☐ No

If yes, drugs of choice

_____

☐ Current Abuse/Dependence

☐ By Family/Significant Other

Other Risk Factors:

☐ Hx Physical/Sexual Abuse

☐ Child/Elder neglect

☐ Anorexia ☐ Bulimia

If risk exists: Client is able to contract not to harm

☐ Self ☐ Others

Patient has been evaluated for psychiatric meds? ☐ Yes ☐ No **Prescribing MD**: ☐ Psychiatrist ☐ PCP Name:_____

CURRENT MEDICATIONS Include all meds psychiatric and medical

Drug	Current Dose	Duration	Drug	Current Dose	Duration

Progress Update

☐ Compliant, Progressing and Improving – Needs more sessions

☐ Compliant, Progressing and Improving – Plan for discharge. When?_____

☐ Compliant, Not Progressing or Improving – Needs Med referral_____

☐ Not Compliant, but at risk. How addressed?_____

☐ Not Compliant, Needs Referral for other Services/Therapy

If Patient needs referral

☐ Have you made the referral? ☐ Yes ☐ No

☐ Can UBH help you with the referral?

☐ Would like to consult with a UBH clinician? MSW MA PhD MD

Expected Outcome and Prognosis

☐ Return to normal functioning

☐ Expect improvement, anticipate less than normal functioning

☐ Relieve acute symptoms, return to baseline functioning

☐ Maintain current status/prevent deterioration

Frequency of sessions:_____

Expected LOS:_____**Discuss**:_____

Modality CPT Code:_____

Attach additional info if needed.

Clinician's Signature_____ **Date**_____

This form is to be used for routine outpatient psychotherapy only