



OSU HEALTH PLAN BEHAVIORAL HEALTH SERVICES TREATMENT PROGRESS RECORD

Client Name		Member ID #	Client Relationship to Member Self _____ Wife _____ Husband _____ Son _____ Daughter _____	
Date of Birth:	Gender: Male _____ Female _____	Client Address:		
Clinician's Name and Licensure:			Tax ID:	
Clinician's Address, Phone, and Fax Number:				
Requested Date for this Authorization to begin		Date of original appointment with this client.		Release of Information Signed? Yes _____ No _____
Provider please check the number of treatment progress records you have sent us regarding this patient. Number: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> More than 6 _____				
Has the Primary Care Physician been updated? Yes <input type="checkbox"/> No <input type="checkbox"/> Name: Dr. _____ Is the patient being seen by a psychiatrist? Yes <input type="checkbox"/> No <input type="checkbox"/> Provider: _____ If client is seeing a psychiatrist for medication has treatment been coordinated with them? Yes <input type="checkbox"/> No <input type="checkbox"/>				
<u>Current Risk Factors</u>				
Suicidality: None _____ Ideation _____ Plan _____ Intent w/o means _____ Intent with means _____ Homicidality: None _____ Ideation _____ Plan _____ Intent w/o means _____ Intent with means _____ If risk exists: Client is able to contract not to harm: Self _____ Others _____ Impulse Control: Sufficient _____ Moderate _____ Minimal _____ Inconsistent _____ Explosive _____ Family/Support system available: Yes _____ No _____ Explain: _____ Medical Risks: Yes _____ No _____ If "Yes" Explain _____				
<u>Substance Abuse-</u> Please fill out the OSU Health Plan Initial Clinical Assessment Report and submit it with the <i>Treatment Progress Record</i> the first time you submit this form. (Or if the clients use of alcohol or other mood altering substances changes significantly).				
<u>Functional Impairments</u> Explain how the client's symptoms impair functioning in each area below, or place client at risk: Severity Rating: 1= Mild 2= Moderate 3= Severe				
Area	Severity	Description		
Job/School	_____	_____		
Relationships/Family	_____	_____		
<u>Diagnosis</u> Use DSM-IV Codes; include all Axes				
Axis I - Primary _____		Secondary _____		Axis II _____
Axis III _____				
Axis IV (Identify Stressors) _____				
Axis V (GAF) Current _____ Highest in last 12 months _____				
<u>Current Medication</u> None _____ Psychiatric _____ Medical _____ No Information _____				
Has client had a psychiatric medication evaluation? Yes _____ No _____				
Specify (include dosage, frequency) if on meds.				
<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Prescribed by</u>	
_____	_____	_____	Primary Care Dr.	Psychiatrist
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Is client compliant with medication as prescribed? Yes _____ No _____				

Symptoms and Problems Rate Severity and duration for each applicable.

Severity Rating: 1= Mild 2= Moderate 3= Severe

Duration Rating 1= Less than 1 month 2= 1 to 6 months 3= 7 to 11 months 4= more than 1 year

	Severity	Duration		Severity	Duration		Severity	Duration
Aggression	_____	_____	Appetite Disturbance	_____	_____	Conduct Problems	_____	_____
Depression	_____	_____	Bizarre Beh./Ideation	_____	_____	Gender Issues	_____	_____
Hyperactivity	_____	_____	Indep. Living Probs	_____	_____	Hallucinations/Delusions	_____	_____
Anxiety	_____	_____	Somatization	_____	_____	Poor Interpersonal skills	_____	_____
Poor Judgement	_____	_____	Impaired Memory	_____	_____	Obsessive Compulsive	_____	_____
Panic Attacks	_____	_____	Paranoid Ideation	_____	_____	Poor Self-Care Skills	_____	_____
Sexual Dysfunction	_____	_____	Sleep Disturbance	_____	_____	Truancy/School Problems	_____	_____

Other(s) _____ Severity _____ Duration _____

Current Treatment Modalities

Family and/or collateral parent therapy is strongly advised for all child and adolescent cases unless contraindicated. For any client, OSU Health Plan expects your treatment to include coordination with other professionals treating this client.

Individual Therapy _____ visit(s) per month Group Psychotherapy _____ visits per month
 Family Therapy _____ visits per month
 Community Resources/Self Help _____ Strongly recommended as adjunct to treatment for ____ Client ____ Family
 List _____

Alternative treatment modalities Proposed: _____

CPT Code used for ongoing sessions, 90806 90847 90857 90807 90853 Other, list 908_____

Justification for frequency > x2/month for any one treatment modality. (Should be based on acuity of symptoms and impact on clients functioning.)

Treatment Goals:

List goals directed at *reducing risk and impairment to function* specified above.

Progress Rating Scale: N - New Goal, 1 - Much worse, 2 - Somewhat worse, 3 - No change, 4 - Slight improvement 5 - Great Improvement, R - Resolved

Measurable, Behavioral Goal	Method(s) for Achieving Goal	Progress Rating (since last report)	Target Date To resolve this goal

Estimated number of sessions to achieve goals and complete treatment _____

Clinician's Signature _____ Date _____

Please attach any other clinical information that will establish rationale for continued certification that has not been addressd above.



For Office Use Only	
Treatment authorization number _____	Date span of authorization _____
Number of sessions authorized _____	CPT Code requested approved <input type="checkbox"/>
	Case Manager _____

OSU HEALTH PLAN BEHAVIORAL HEALTH SERVICES PSYCHIATRIC MEDICATION MANAGEMENT RECORD

This form is to be used by psychiatrists when visits are exclusively medication visits of 30 minutes or less. If seeing the patient for longer periods of time or counseling is the focus of the visit, the *Treatment Progress Record* should be used.

Client Name _____		Member ID # _____	Client Relationship to Member: Self _____ Wife _____ Husband _____ Son _____ Daughter _____	
Date of Birth: _____	Gender: Male _____ Female _____	Client Address: _____		
Clinician's Name and Licensure: _____			Tax ID: _____	
Clinician's Address, Phone, and Fax Number _____				
Requested Date for this authorization to begin _____		Date of original appointment with this client? _____	Release of Information Signed Yes _____ No _____	
Has the Primary Care Physician been updated? Yes _____ No _____ Name: Dr. _____ Is the patient being seen by a counselor? Yes _____ No _____ Provider: _____ Is there a coordination of treatment goals between the psychiatrist, counselor, and/or primary provider? Yes _____ No _____				
Current Risk Factors _____ No current risks or changes since last update (Skip to next section)				
Suicidality: None _____ Ideation _____ Plan _____ Intent w/o means _____ Intent with means _____ Past history of suicide attempts _____				
Homicidality: None _____ Ideation _____ Plan _____ Intent w/o means _____ Intent with means _____				
Impulse Control: Sufficient _____ Moderate _____ Minimal _____ Inconsistent _____ Explosive _____				
Family/Support system available: Yes _____ No _____ Explain _____				
Medical Risks: Yes _____ No _____ If "Yes" Explain _____				
Substance Abuse Please fill out the <i>OSU Health Plan Initial Clinical Assessment</i> Report and submit it with the <i>Psychiatric Medication Management Record</i> the <u>first time</u> you submit this form. (Or if the client's use of alcohol or other mood altering substances changes significantly)				
Functional Impairments Explain how the client's symptoms impair functioning, or place client at risk: Severity Rating: 1= Mild, 2= Moderate, 3= Severe			CPT Code used:	
Area	Severity	Description	90805 <input type="checkbox"/>	908 _____ <input type="checkbox"/>
Job/School _____			90807 <input type="checkbox"/>	
Relationship/Family _____			90862 <input type="checkbox"/>	
Diagnosis Use DSM-IV Codes; include <u>all</u> Axes				
Axis I- Primary _____		Secondary _____		Axis II _____
Axis III _____				
Axis IV (Identify Stressors) _____				
Axis V (GAF) Current _____		Highest in last 12 months _____		
Current Medication None _____ Psychiatric _____ Medical _____ No Information _____				
Specify (include dosage, frequency) if on meds.				
Medication	Dosage	Frequency	Prescribed by	
			Primary Care Dr.	Psychiatrist
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Is client compliant with medication as prescribed? Yes _____ No _____				
Expected visits next 12 months. (Circle) 1 2 3 4 5 6 7 8 9 10 11 12. (If more please use the <i>OSU Health Plan Treatment Progress Record</i> .)				