



OSU HEALTH PLAN BEHAVIORAL HEALTH SERVICES
TREATMENT PROGRESS RECORD

Form containing fields for Client Name, Member ID #, Date of Birth, Gender, Client Address, Clinician's Name and Licensure, Tax ID, Requested Date for Authorization to begin, Date of original appointment with this client, Release of Information Signed, Current Risk Factors, Substance Abuse, Functional Impairments, Diagnosis, and Current Medication.

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.