USFHP Behavioral Medicine Department
1200 12TH Avenue South, Seattle, WA 98144

Outpatient Treatment Report/Re-Authorization

Uniformed Services Family Health Plan (USFHP) requires this information to assess the medical necessity of outpatient assessment and treatment for beneficiaries in managed care programs. Further care cannot be authorized until we have reviewed this report. Please direct your questions to the Referral Coordinator at **Phone:** (206) 326-2453, option 1; **Fax:** (206) 621-4026

Patient Name:	Provider Name:	
Patient DOB:	Provider Phone:	Provider Fax:
Patient USFHP ID:	Date of First Session:	
Age:	PCP:	
Number of sessions/hours of testing already used during FY **(Fiscal Year = 10/1 to 9/30)**:		
Estimated # of sessions, beyond those already authorized, needed to achieve termination?		

To be filled out by USFHP Behavioral Medicine Case Manager (CM)

CM Name:	
Authorization #:	Authorization date span:
Re-Authorized for:	Re-Authorization date:
Denial Information:	

Diagnosis (Use DSM-V)

Presenting Problem (Circle all that apply)

Child behavior problem	Parenting problem	Grief/Loss
Problem w/ Spouse or Partner	Psychological difficulties	Physical concern
Problem with other family member	Supervisory referral	Court directed
Difficulties at work or school	Alcohol/Drug use	Legal or financial difficulties

Primary Approach (Circle one)

Crisis Stabilization	Psycho-Edu Assessment	Neuro-psych Assessment
Supportive Maintenance	Focused Symptom Reduction or Behavior Change	Major Personality Change

Medication Management:

Proposed Treatment Plan

Modality	How often	Start date	Target end date	Estimated # of sessions
Medication Management				
Individual Therapy				
Family Therapy (b/w adult and children <18) Couples/Marriage Therapy **is not** a covered benefit				
Group Therapy				
Psychological Testing				
Other interventions (pls explain)				

Please rate severity of *CURRENT* symptoms (**Note:** Those **not** checked will be assumed absent**)**

Symptom	Mild	Moderate	Severe
Depression			
Hopelessness			
Anxiety / Panic			
Mania			
Phobias			
Sexual disorder or dysfunction			
Obsessions / Compulsions			
Delusions			
Hallucinations			
Disruption of thought process or content			
Dissociative disorder			
Sleep disturbance			
Misbehavior (child)			
Aggressiveness			
Alcohol use			
Drug use			
Other			

Suicide risk (circle if applicable): Low Moderate High

Suicidality: Ideation Plan Gestures Attempts

Describe gestures or attempts: _____

How recently: _____

Physical violence risk (circle if applicable): Low Moderate High

Describe history of violence: _____

Psychiatric Medications

Current psychiatric meds patient is taking
Do you believe the current medication is adequate
If not what actions are needed to review medication(s)
If patient is not on psych medications, would they be helpful now?
If yes, what actions are you taking to have med needs assessed?
Other psychosocial treatments or self-help groups in which patient is involved?

Reviewer's Notes: **Please attach your notes to the form and mark "Confidential"**