PASSPORT ADVANTAGE (HMO SNP)

Mental Health/ Substance Abuse Outpatient Treatment Review Form

Fax: 1-844-602-4630

UM Department Phone: 1-866-816-1722

Member: _____ Provider Name: _____ Provider Telephone: _____

Member DOB: _____ Provider Group/Clinic: _____ Provider Fax: _____

Member ID: _____ Service Address: _____ City/State/Zip: _____

Provider ID/NPI: _____ Tax ID# _____

Mental Health/Substance Abuse History

☐ Yes ☐ No Previous Mental Health or Substance Abuse treatment inpatient/outpatient:

Level of care:	Dates Tx:
Level of care:	Dates Tx:
Level of care:	Dates Tx:

☐ Yes ☐ No Drug/Alcohol Use (For Past 12 Months) If **YES** complete the following:

Substance	Amount	Frequency	Age Began	Last Used

For Current Substance Abuse Treatment:

Attended AA/NA? ☐ Yes ☐ No Linked to a Sponsor? ☐ Yes ☐ No

TOXICOLOGY

Date	NEG	POS	Substance	Notes

Toxicology Substance: ALC: Alcohol; AMP: Amphetamine: BAR: Barbiturates: BEZ: Benzodiazepine: COC: Cocaine; MET: Methadone; Opiate OPI: Opiates; PCP; PM: Prescription Medication: SUB: Suboxone: THC: THC

Current Signs/Symptoms (please check box if currently present):

☐	Generalized Anxiety	☐	Pressured Speech	☐	Loose Associations
☐	Depressed Mood	☐	Weight Loss/Gain	☐	Psychomotor Retardation
☐	Appetite Disturbance	☐	Panic Attacks	☐	Concentration/Attention Problems
☐	Sleep Disturbance	☐	Phobias	☐	Impulse Control Problems
☐	Low Energy	☐	Obsessions/Compulsions	☐	Conduct Problems
☐	Agitation	☐	Circumstantial/Tangential	☐	Oppositional Behaviors
☐	Labile	☐	Sexual Dysfunction	☐	Acute Stress Disorder
☐	Irritability	☐	Paranoid Ideation	☐	Other:

Mental Status (please check box if present):

☐	Oriented x3	☐	Impaired Memory	☐	Delusions- Type:
☐	Impaired Judgment	☐	Other Cognitive Impairment:	☐	Hallucinations- Type:

Member:_____ **ID#**_____

Risk Assessment (please check NO if not present- if checked, please provide additional information)

☐ Yes ☐ No	SUICIDAL RISK:	☐ Yes ☐ No	HOMICIDAL RISK:	☐ Yes ☐ No	ABUSE RISK:
☐ Yes	Ideation	☐ Yes	Ideation	☐ Yes	Ideation
☐ Yes	Intent	☐ Yes	Intent	☐ Yes	Intent
☐ Yes	Plan	☐ Yes	Plan	☐ Yes	Plan
☐ Yes	Means	☐ Yes	Means	☐ Yes	Means
☐ Yes	Attempt	☐ Yes	Attempt	☐ Yes	Attempt

Medication Name/Dosage/Frequency: **Rx by:** ☐ **Psychiatrist** ☐ **PCP** **Not applicable:** ☐

1.
2.
3.

Diagnosis (please include Mental Health (DSM-5 or ICD-10) and other applicable co-occurring diagnoses)
Axis I:
Psychosocial Stressors:

Treatment Plan

GOAL #
Progress/Lack of Progress on Goal:
Goal Status: ☐ Accomplished & Removed ☐ Continue ☐ Additional Progress Needed ☐ Revised –See New goal/objective

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Member:_____ **ID#**_____

Discharge criteria/Plan:
Number of sessions estimated to complete this episode of care:

Treatment Request

Date of first visit for this episode of care: _____

Number of sessions to date: _____

Requested Start Date for this registration: _____

Please indicate type(s) of service requested and frequency:

❑ Initial Diagnostic Evaluation (90791) with Medical (90792)

❑ Family Psychotherapy (45-50min) 90847

❑ Wkly ❑ Mthly ❑ Qrtly ❑ Other: _____

❑ Indiv. Psychotherapy (45min) 90834

❑ Wkly ❑ Mthly ❑ Qrtly ❑ Other: _____

❑ Group Psychotherapy (60-90min) 90853

❑ Wkly ❑ Mthly ❑ Qrtly ❑ Other: _____

❑ Indiv. Psychotherapy (60min) 90837

❑ Wkly ❑ Mthly ❑ Qrtly ❑ Other: _____

❑ Other: _____

❑ Wkly ❑ Mthly ❑ Qrtly ❑ Other: _____

Clinician Signature: _____ Date: _____