BlueCross BlueShield of Western New York

Mental Health Outpatient Treatment Review Form Fax: (716) 887-7913 Customer Services: 1-877-837-0814

Member: _____ **Provider name:** _____ **Provider telephone**: _____

Member DOB: _____ **Provider group/clinic:** _____ **Provider fax**: _____

Member ID: _____ **Service address**: _____ **City/State/ZIP:** _____

Provider ID/NPI: _____

Mental Health/Substance Abuse History

☐ **Yes** ☐ **No** Previous mental health treatment inpatient/outpatient? If **YES**, complete the following:

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

☐ **Yes** ☐ **No** Drug/alcohol use (in past 12 months)? If **YES** complete the following:

Substance	Amount	Frequency	Age began	Last used

Clinical Assessment

Current Signs/Symptoms

☐ **Yes** ☐ **No**	Generalized anxiety	☐ **Yes** ☐ **No**	Pressured speech	☐ **Yes** ☐ **No**	Loose associations
☐ **Yes** ☐ **No**	Depressed mood	☐ **Yes** ☐ **No**	Weight loss/gain	☐ **Yes** ☐ **No**	Psychomotor retardation
☐ **Yes** ☐ **No**	Appetite disturbance	☐ **Yes** ☐ **No**	Panic attacks	☐ **Yes** ☐ **No**	Concentration/attention problems
☐ **Yes** ☐ **No**	Sleep disturbance	☐ **Yes** ☐ **No**	Phobias	☐ **Yes** ☐ **No**	Impulse control problems
☐ **Yes** ☐ **No**	Low energy	☐ **Yes** ☐ **No**	Obsessions/compulsions	☐ **Yes** ☐ **No**	Conduct problems
☐ **Yes** ☐ **No**	Agitation	☐ **Yes** ☐ **No**	Circumstantial/tangential	☐ **Yes** ☐ **No**	Oppositional behaviors
☐ **Yes** ☐ **No**	Labile	☐ **Yes** ☐ **No**	Sexual dysfunction	☐ **Yes** ☐ **No**	Acute stress disorder
☐ **Yes** ☐ **No**	Irritability	☐ **Yes** ☐ **No**	Paranoid ideation	☐ **Yes** ☐ **No**	Other

Mental Status

☐ **Yes** ☐ **No**	Oriented x3	☐ **Yes** ☐ **No**	Impaired memory	☐ **Yes** ☐ **No**	Delusions
☐ **Yes** ☐ **No**	Impaired judgment	☐ **Yes** ☐ **No**	Other cognitive impairment	☐ **Yes** ☐ **No**	Hallucinations

Risk Assessment

☐ **Yes** ☐ **No**	SUICIDAL RISK:	☐ **Yes** ☐ **No**	HOMICIDAL RISK:	☐ **Yes** ☐ **No**	ABUSE RISK:
☐ **Yes** ☐ **No**	Ideation	☐ **Yes** ☐ **No**	Ideation	☐ **Yes** ☐ **No**	Verbal
☐ **Yes** ☐ **No**	Intent	☐ **Yes** ☐ **No**	Intent	☐ **Yes** ☐ **No**	Emotional
☐ **Yes** ☐ **No**	Plan	☐ **Yes** ☐ **No**	Plan	☐ **Yes** ☐ **No**	Physical
☐ **Yes** ☐ **No**	Means	☐ **Yes** ☐ **No**	Means	☐ **Yes** ☐ **No**	Sexual
☐ **Yes** ☐ **No**	Attempt	☐ **Yes** ☐ **No**	Attempt		

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

1.

2.

3.

Diagnosis (please include all diagnoses including mental health and medical, if applicable)

Member:	**ID#**
Treatment Plan	
GOAL #	
Progress/lack of progress on goal:	
Goal status: ☐Accomplished and removed ☐ Continue ☐ Additional progress needed ☐ Revised – see new goal/objective	
GOAL #	
Progress/lack of progress on goal:	
Goal status: ☐Accomplished and removed ☐ Continue ☐ Additional progress needed ☐ Revised – see new goal/objective	
GOAL #	
Progress/lack of progress on goal:	
Goal status: ☐Accomplished and removed ☐ Continue ☐ Additional progress needed ☐ Revised – see new goal/objective	
Discharge criteria/plan:	

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:	
☐**Medication management** ☐Wkly ☐Mthly ☐Qrtly ☐Other	☐**Family psychotherapy (45-50 min.)** ☐Wkly ☐Mthly ☐Qrtly ☐Other
☐**Individual psychotherapy (20-30 min.)** ☐Wkly ☐Mthly ☐Qrtly ☐Other	☐**Group psychotherapy (60-90 min.)** ☐Wkly ☐Mthly ☐Qrtly ☐Other
☐**Individual psychotherapy (45-50 min.)** ☐Wkly ☐Mthly ☐Qrtly ☐Other	☐**Other** ☐Wkly ☐Mthly ☐Qrtly ☐Other
Clinician signature:	Date: