BlueCross BlueShield of Western New York

Behavioral Health Utilization Management

Fax: (716) 887-7913
Customer Service: 1-877-837-0814

Outpatient Treatment Review Form

Chemical Dependency

Member: _____ **Provider name:** _____ **Provider phone**: _____
Member DOB: _____ **Provider group/clinic:** _____ **Provider fax**: _____
Member ID: _____ **Service address**: _____ **City/State/ZIP:** _____
Provider ID/NPI: _____

Substance Abuse History (including alcohol, drugs, and prescription medication)

☐Yes ☐No Previous substance abuse 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

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Attended Alcoholics Anonymous (AA)/Narcotics Anonymous (NA)? ☐Yes ☐No **Linked to a sponsor** ☐Yes ☐No

TOXICOLOGY

Date	NEG	POS	Substance	Notes
	☐	☐		
	☐	☐		
	☐	☐		

Toxicology Substance: Alcohol (ALC), Amphetamine (AMP), Barbiturates (BAR), Benzodiazepine (BEZ), Cocaine (COC), Methadone (MET), Opiates (OPI), Phencyclidine (PCP), Prescription Medication (PM), Suboxone (SUB), Tetrahydrocannabinol (THC)

Discharge criteria/plan:

Expected number of sessions required to conclude this treatment 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:

☐**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: