

PATIENT NAME (LAST, FIRST) DOB INSURANCE CODE (From Authorization)

AETNA HS MH2 PB TMG

CHIPA AUTHORIZATION NUMBER First Date of Treatment Last Date of Treatment

DSM IV Diagnosis Code(s) or Description

Axis I _____ Secondary: _____

Axis II _____

Axis III _____

Axis IV None Mild Moderate Severe

Axis V Current Last Reported Highest Past Year

PLEASE CHECK ALL THE APPROPRIATE BOXES FOR EACH SECTION

Treatment History

Is compliance with medical treatment a problem? Yes No

How many times has the patient been hospitalized for a psychiatric condition?

None	1	2	3+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the hospitalization occurred within the past 12 months, how long ago was the most recent episode?

0-3 Mos	4-6 Mos	7-12 Mos
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Substance Abuse History

Does the patient currently have a substance abuse problem? Yes No

Is the patient receiving, or has received treatment for substance abuse? Yes No

What type(s) of treatment has the patient received for substance abuse? 12 Step OP IP NA

Functional Impairments and Symptoms

	None	Mild	Mod	Sev
Impaired Family Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Physical Well Being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homicidal Ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binging/Purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inattention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Destruction of Property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Academic Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medications and Coordination of Care

Does patient have referral for med eval? Yes No

Is the patient currently taking meds? Yes No

Who is Prescribing? IF NO PLEASE SKIP TO FINAL QUESTION

I am prescribing Psychiatrist PCP Other _____

Types of Medication

<input type="checkbox"/>	Anti-Depressant	<input type="checkbox"/>	Anti-Anxiety
<input type="checkbox"/>	Anti-Psychotic	<input type="checkbox"/>	Sedative-Hypnotic
<input type="checkbox"/>	Mood Stabilizer	<input type="checkbox"/>	Stimulant
<input type="checkbox"/>	Other		

Is patient compliant with medication? Yes No

If you are not the prescribing provider, have you communicated with him/her? Yes No

Have you communicated with PCP? Yes No

Narrative Progress Note (optional):

Authorization Request

Total Sessions To Date* Additional Sessions Requested Or Treatment Terminated

*From start of treatment

CPT Code Requested 90862 90805 90806 90807 90847 90853

Other _____

Provider Name _____ Telephone Number _____

Group Practice _____ Fax Number _____

Signature _____ Date Completed _____