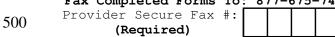




## **Outpatient Treatment Report**

Provider Name & License/Certification Type (Please Print):

Member Name (Please Print):					_
Member ID #:	$\Box$				
Tax ID #:					
$100B \cdot I  I  I  I  I  I  I  I  I  I$	odes Requ			<b>Medica</b> -depress	ant 🗌
Axis I:  Axis II:  Axis III:  Check box if member previously hospitali  Check box if member previously hospitali  Check box if member pregnant.	zed.		A Mood	Medicat Ot	ety
Provider Signature: Date	= Signea	: [	'		
FUNCTIONAL IMPAIRMENT RATING SCALE  Fill in the bubble like this   to indicate current level of impairment in each domain.	CUF None	RENT LE	VEL OF I	MPAIRMEN	IT Severe
Affective Depression, mania, mood instability, inappropriate mood	0	0	0	0	0
Anxiety Panic, worry, anxiety, easily startled, flashbacks, nightmares	0	0	0	0	0
ADHD Symptoms Hyperactivity, impulsivity, poor insight, poor judgment	0	0	0	0	0
Obsessions & Compulsions Rituals, fear of contamination, excessive need for orderliness, hair pulling, unacceptable impulses	0	0	0	0	0
Reality Construction & Thought processes Delusions, hallucinations, disorganized or racing thoughts, dissociative states, paranoia	0	0	0	0	0
<pre>Cognitive Cognitive impairments due to organic conditions including brain trauma, dementia and mental retardation</pre>	0	0	0	0	0
Social Difficulty forming positive relationships, social isolation, anger/aggression, interpersonal problems at work/school	0	0	0	0	0
Substance Abuse Problematic use of drugs or alcohol	0	0	0	0	0
Harm to Self or Other Suicidal ideation, intentionally self injurious behavior, suicide planning, danger to others	0	0	0	0	0
Appetite & Eating Disturbances in appetite, anorexia or bulimia	0	0	0	0	0
Sleep Disturbances in sleep patterns, including excessive sleep	0	0	0	0	0
Other Medical Conditions  Presence of medical conditions which have significant impact on patient functioning and/or quality of life	0	0	0	0	0
Fax Completed Forms To: 877-675-7421					



State: (Required)

