Carrier Information

Name:

Address:

Phone No. (   )

Fax No. (   )

State of Maryland

Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

☐ Initial Plan ☐ Continuing Report

Beginning date for current authorization request ____________
month/date/year

Patient First Name	Membership Number	Group Number	Patient Date of Birth MO DAY YR	Relationship to insured

Clinician/Provider Name (Please Print)	Credentials (Lic/Cert#)	Supervisor (If applicable)	Phone
Address	Phone	Address	
I.D. (If applicable)	Fax	Clinician Signature	Date

PART 1 - PREVIOUS TREATMENT PAST TWO YEARS (Complete for initial plan only)

	Yes	No	Unknown
Outpatient	☐	☐	☐
Partial Hospital	☐	☐	☐
Residential Tx Center	☐	☐	☐
Sub Abuse Intensive Outpatient	☐	☐	☐
Other: ____________	☐	☐	☐

Medical Hx:____________

Psychiatric Medications (List if known, include name and dose):____________

Compliance: Yes ☐ No ☐ Side Effects: Yes ☐ No ☐

Comments: ____________

Allergies:____________

PART 2 - CURRENT DIAGNOSIS/ASSESSMENT

DSM-IV DIAGNOSIS

Axis I: ___ . __ ___ . __ ___ . __

Axis II: ___ . __ ___ . __

Axis III

Axis IV

Axis V: Current____ Highest in last year

(Document specific GAF score - not range)

FUNCTIONAL ASSESSMENT

Category	Illness-related Impairment			
	None	Mild	Moderate	Severe
Family Relations	☐	☐	☐	☐
Job/School	☐	☐	☐	☐
Financial	☐	☐	☐	☐
Physical Health	☐	☐	☐	☐
Legal	☐	☐	☐	☐
Friends/Social	☐	☐	☐	☐

RISK ASSESSMENT: Suicidality: ☐ Ideation ☐ Plan ☐ Prior attempts (if known) ☐ Other Risk Behavior (e.g., dangerousness to others, self mutilation, etc.) Comments:____________

OTHER ASSESSMENT INFO (e.g. psychological testing, type and amount of drug(s) of abuse, specific weight gain/loss)____________

RISK OF RELAPSE INTO CHRONIC/ACUTE SYMPTOMS: ☐ High ☐ Moderate ☐ Low Comments:____________

PART 3 - THERAPEUTIC INTERVENTIONS

A. PROPOSED TREATMENT (Check all services for which authorization is requested)

Modality	Frequency (e.g. 2/wk, 1/mo)	CPT Code
☐ Individual	____/____	________
☐ Group	____/____	________
☐ Family	____/____	________
☐ Medication	____/____	________
☐ Conjoint	____/____	________
☐ Other (Specify Code): ________	____/____	________

Date first seen for current episode: ____/____/____

Estimated discharge date: ____/____/____

Expected number of visits ________

B. PSYCHIATRIC MEDICATION

Has patient been evaluated for medication? ☐ Yes ☐ No

Does patient follow medication regimen? ☐ Yes ☐ No

Medication	Dose/Frequency	Start Date

Comments: (e.g., lab results, prescriber, side effects)

____

C. OTHER PSYCHIATRIC, MEDICAL OR COMMUNITY SUPPORT SERVICES CLIENT RECEIVES: (Specify e.g., NA/AA , group therapy, supportive housing, treatment for medical problems):________________________

D. EXPECTED TREATMENT OUTCOMES (check all that apply)

- ☐ Reduction in symptoms and discharge from active treatment
- ☐ Return to highest GAF and discharge from active treatment
- ☐ Transfer to self help/other supports and discharge from active treatment
- ☐ Ongoing supportive counseling to maintain stabilization of symptoms
- ☐ Ongoing medication management to maintain stabilization of symptoms

PART 4 - PRESENTING SYMPTOMS TARGETED SYMPTOMS

Mark only those symptoms that apply based on the past 2 weeks or most recent visit. Indicate if the symptom is a target of treatment. Also check target if symptom is currently controlled by medication.

SOCIAL FUNCTIONING/BEHAVIOR

Mild	Mod	Severe	Target	Symptom
☐	☐	☐	☐	______Socially isolated
☐	☐	☐	☐	______Unstable/intense relationships
☐	☐	☐	☐	______Perfectionistic/controlling/rigid
☐	☐	☐	☐	______Distrustful/suspicious
☐	☐	☐	☐	______Noncomforming to laws/norms
☐	☐	☐	☐	______Threatening
☐	☐	☐	☐	______Assaultive
☐	☐	☐	☐	______Tantrums
☐	☐	☐	☐	______Self mutilating
☐	☐	☐	☐	______Impulsive
☐	☐	☐	☐	______Oppositional/defiant
☐	☐	☐	☐	______Work/school inhibition
☐	☐	☐	☐	______Agitation
☐	☐	☐	☐	______Motor retardation
☐	☐	☐	☐	______Hyperactive
☐	☐	☐	☐	______Disorganized
☐	☐	☐	☐	______Other________________

COGNITION/MEMORY/ATTENTION

Mild	Mod	Severe	Target	Symptom
☐	☐	☐	☐	______Impaired attention/concentration
☐	☐	☐	☐	______Memory impairment
☐	☐	☐	☐	______Concrete thinking
☐	☐	☐	☐	______Disorientation to : time/place/person
☐	☐	☐	☐	______Impaired judgment
☐	☐	☐	☐	______Lack of insight
☐	☐	☐	☐	______Circumstantiality/tangentiality
☐	☐	☐	☐	______Flight of ideas/racing thoughts
☐	☐	☐	☐	______Distorted idiosyncratic thinking
☐	☐	☐	☐	______Other________________

MOOD/AFFECT DISTURBANCE

Mild	Mod	Severe	Target	Symptom
☐	☐	☐	☐	______Suicidal ideation
☐	☐	☐	☐	______Homicidal ideation
☐	☐	☐	☐	______Depressed mood
☐	☐	☐	☐	______Elated mood
☐	☐	☐	☐	______Labile Mood
☐	☐	☐	☐	______Low esteem/excessive guilt
☐	☐	☐	☐	______Hopelessness/helplessness
☐	☐	☐	☐	______Irritability/inappropriate anger
☐	☐	☐	☐	______Loss of interest/anhedonia
☐	☐	☐	☐	______Other________________

SOMATIC DISTURBANCE

Mild	Mod	Severe	Target	Symptom
☐	☐	☐	☐	______Hypersommia
☐	☐	☐	☐	______Insomnia
☐	☐	☐	☐	______Vomiting/laxative/diuretic abuse
☐	☐	☐	☐	______Body weight change
☐	☐	☐	☐	______Pain
☐	☐	☐	☐	______Other________________

ANXIETY

Mild	Mod	Severe	Target	Symptom
☐	☐	☐	☐	______Avoidant behavior
☐	☐	☐	☐	______Phobia
☐	☐	☐	☐	______Obsessions/compulsions
☐	☐	☐	☐	______Panic attacks
☐	☐	☐	☐	______Somatization
☐	☐	☐	☐	______Generalized anxiety
☐	☐	☐	☐	______Separation anxiety
☐	☐	☐	☐	______Other________________

PERCEPTUAL DISTURBANCE

Mild	Mod	Severe	Target	
☐	☐	☐	☐	________Hallucinations
☐	☐	☐	☐	________Delusions
☐	☐	☐	☐	________Ideas of reference
☐	☐	☐	☐	________Flashbacks
☐	☐	☐	☐	________Depersonalization/dissociation
☐	☐	☐	☐	________Other______________

SUBSTANCE USE

Mild	Mod	Severe	Target	
☐	☐	☐	☐	________Cont. use in spite of knowledge of effects
☐	☐	☐	☐	________Inability to control/decrease use
☐	☐	☐	☐	________Persistent desire for substance
☐	☐	☐	☐	________Tolerance
☐	☐	☐	☐	________Withdrawal
☐	☐	☐	☐	________Other__________________

Last date of substance use: _____/_____/_____

PART 5 ADDITIONAL INFORMATION

For first reviews, briefly state additional information which may help clarify the need for this outpatient treatment, including frequency of targeted behaviors and, where applicable, onset of specific symptoms. For subsequent reviews, briefly state what progress has been made. If no progress, indicate reasons and whether treatment plan is being revised to address targeted symptoms.

Treatment plan discussed with patient, guardian or other legal representative (if applicable), or parent of a minor ☐ Yes ☐ No

Treatment coordinated with primary care physician ☐ Yes ☐ No ☐ Not applicable

Are additional health services required? ☐ Yes ☐ No Referred to: ______________________ Date: __________