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#)

Address Phone

I.D. (If applicable) Fax

Supervisor (If applicable) Phone

Address

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	
☐	☐	☐	☐	_____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	
☐	☐	☐	☐	_____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	
☐	☐	☐	☐	_____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	
☐	☐	☐	☐	_____Hypersommia
☐	☐	☐	☐	_____Insomnia
☐	☐	☐	☐	_____Vomiting/laxative/diuretic abuse
☐	☐	☐	☐	_____Body weight change
☐	☐	☐	☐	_____Pain
☐	☐	☐	☐	_____Other_____

ANXIETY

Mild	Mod	Severe	Target	
☐	☐	☐	☐	_____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: _____