



## Continued Outpatient Treatment Notification Form

This form is only necessary if the patient has had 10 visits in the calendar year.

**Member Information:**

Member Name: \_\_\_\_\_

Member Recipient ID: \_\_\_\_\_

DOB: \_\_\_\_\_

Date of Initial Visit: \_\_\_\_\_

# of visits to date: \_\_\_\_\_

# of additional visits anticipated: \_\_\_\_\_

Start date for continued visits: \_\_\_\_\_

**DSM IV Axis:**

I. \_\_\_\_\_

II. \_\_\_\_\_

III. Please circle member's medical conditions:

*None Asthma/COPD Cancer Cardiovascular Problems Chronic Pain Dementia Diabetes*

*Other:* \_\_\_\_\_

IV. \_\_\_\_\_

V. \_\_\_\_\_ Current (GAF)

Procedures Codes (CPT): \_\_\_\_\_

**Plan for members at Benefit Exhaustion:**

Remaining visits will be spread across the rest of the benefit year.

Client will be referred to CMH once their benefits are exhausted.

Client will be discharged successfully.

**Provider Information:**

Agency Name: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Primary Care Physician (PCP) Communication:**

Has information been shared with the PCP?

Yes  No  Patient Refused Permission

PCP Name: \_\_\_\_\_

Date last notified: \_\_\_\_\_

Did the member participate in their treatment plan?

Yes  No

Has member been prescribed medication?

Yes  No

If yes, names: \_\_\_\_\_

Prescribing physician: \_\_\_\_\_

This patient requires additional sessions because the patient is/has:

resistant to treatment

ongoing medication management

additional sessions need to support termination of therapy

maintenance treatment required to maintain optimal symptom relief

significant life event complicating treatment

not at baseline functioning