

South Carolina Non-Network Outpatient Treatment Report

PLEASE FILL OUT ALL **APPLICABLE** AREAS

Patient's Name:		Clinician:	
ID Card #:		Phone:	
DOB:		Fax:	
Date Of Initial Visit:		Service Location	
Individual NPI:		Address:	
		City & State:	
		Group NPI:	

Since initial visit, has patient been admitted to: Inpatient PHP IOP

Treatment History (check all that apply)	PSYCH	CD	Specify Dates of Treatment
None	<input type="checkbox"/>	<input type="checkbox"/>	_____
Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inpatient:			
Last 90 Days	<input type="checkbox"/>	<input type="checkbox"/>	_____
Last 12 Months	<input type="checkbox"/>	<input type="checkbox"/>	_____
>12 Months	<input type="checkbox"/>	<input type="checkbox"/>	_____
1 prior admit	<input type="checkbox"/>	<input type="checkbox"/>	_____
>2 prior admits	<input type="checkbox"/>	<input type="checkbox"/>	_____

Functional Disabilities (circle and rate all that apply)

	NONE	MILD	MODERATE	SEVERE	DESCRIBE
Marriage/Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social/Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Appearance/Grooming/Dress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Work/School Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Inattention/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression/Labile Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety/Panic/OCD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Somatic Complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hallucinations/Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Co-morbid Substance Use:	Name of substance(s) _____	Frequency _____	Amount _____
	Name of substance(s) _____	Frequency _____	Amount _____
Has patient been referred to	<input type="checkbox"/> AA	<input type="checkbox"/> CD Treatment	

Self/other Harm	<input type="checkbox"/> Passive	<input type="checkbox"/> Thoughts	<input type="checkbox"/> Plan	<input type="checkbox"/> Intent	Comments: _____
Appetite: Current	Ht _____	Wt _____ lbs	<input type="checkbox"/> Weight Loss _____ lbs	<input type="checkbox"/> Weight Gain _____ lbs	In last _____ Months
Sleep Disorder: Total Hours/Night _____	Problems:	<input type="checkbox"/> Falling Asleep	<input type="checkbox"/> Staying Asleep	<input type="checkbox"/> Wake Up on Time	

Symptoms have been present for: Less than 1 Month 1-6 Months 7-11 Months More than a Year

Target Symptoms/Functional Disabilities

Please provide the following information on the three most significant problems you have identified. Circle the appropriate choice based on a scale of 1-5 where 1 is "minimal" and 5 is "severe."

1. _____	Start of treatment	1	2	3	4	5	Current	1	2	3	4	5
2. _____	Start of treatment	1	2	3	4	5	Current	1	2	3	4	5
3. _____	Start of treatment	1	2	3	4	5	Current	1	2	3	4	5

Progress in Treatment (check one only):

- | | |
|--|---|
| <input type="checkbox"/> Continues with/or reoccurrence of acute presenting symptoms | <input type="checkbox"/> Needs support/maintenance only |
| <input type="checkbox"/> Mild to Moderate improvement | <input type="checkbox"/> Greatly Improved |
| <input type="checkbox"/> Nearly Completed with Treatment | <input type="checkbox"/> Other |

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
- Provider ongoing supportive counseling to maintain stabilization of symptoms

Current Medication	Name	Dose	Frequency	Side Effects
<input type="checkbox"/> New	1. _____	_____	_____	_____
<input type="checkbox"/> New	2. _____	_____	_____	_____
<input type="checkbox"/> New	3. _____	_____	_____	_____
<input type="checkbox"/> New	4. _____	_____	_____	_____

Compliance >90% 50-90% <50%

Reasons for Noncompliance:	_____

Diagnosis	
Axis I: _____	Axis V: Initial GAF: _____
	Current GAF: _____
Axis II: _____	Start of certification: _____
Axis III: _____	Last office visit: _____
	When do you want this certification to start? _____
Axis IV: _____	

CPT	Frequency	CPT	Frequency
90804 <input type="checkbox"/>		90847 <input type="checkbox"/>	
90805 <input type="checkbox"/>		90853 <input type="checkbox"/>	
90806 <input type="checkbox"/>		90862 <input type="checkbox"/>	
90807 <input type="checkbox"/>		Other <input type="checkbox"/>	
90846 <input type="checkbox"/>		Other <input type="checkbox"/>	

Clinician's Signature: _____ **Date:** _____

*****Contact with the prescribing or referring physician is strongly recommended**

Date of contact: _____ Method of Contact: Telephone Fax Progress Note

Additional Clinical Information/Progress Since Last Update: _____
