Behavioral Health Service Request Form

Routine Outpatient Services

Treatment Phase: Initiation (0-3 months) : ☐ Continuation (3-6 months): ☐ Stabilization/Maintenance (over 6 months) : ☐

Are services requested court-ordered? ☐ **Yes** ☐ **No** ***If yes, please submit a copy of the court order and all supporting documentation.***

RISK FACTORS AND SYMPTOMS

Please describe the member's baseline behavior :

	Past 12 months	More than 12 months ago	Never
Inpatient admissions for behavioral health/substance abuse treatment?	☐	☐	☐

Current Severity Rating					
Functional Area	None	Mild	Moderate	Severe	Explain Rating
Risk of harm to self or others	☐	☐	☐	☐	
Impairment of psychological functioning	☐	☐	☐	☐	
Impairment of social functioning (family/school/work)	☐	☐	☐	☐	
Impairment of physical functioning	☐	☐	☐	☐	
Impairment in support systems	☐	☐	☐	☐	
Other (list)	☐	☐	☐	☐	

If substance abuse identified please provide details:

Name of substance used	Date of first use	Frequency of use	Date of last use

Treatment	
Functional Area	**Narrative explaining treatment interventions in each functional area of concern:**
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	

Discharge Goal	
Functional Area	**Narrative describing discharge goals for each functional area of concern:**
Risk of harm to self or others	
Impairment of psychological functioning	

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Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	
Discharge plan (date)	

Adherent to therapy?	☐ Yes ☐ No	Adherent to medications?	☐ Yes ☐ No

Please list rationale for additional therapy sessions:

Has the member made progress in treatment? ☐ **Yes** ☐ **No**
If yes, please describe:
If no, how has the treatment plan been modified accordingly?

Does member have access to competent and available supports? ☐ **Yes** ☐ **No** **Please explain:**

Does the member have transportation to and/or from services? ☐ **Yes** ☐ **No**

*****Please submit a copy of the member's most recent Treatment Plan.**