



OUTPATIENT CONCURRENT REVIEW

Level of Care: Outpatient Non-OMS ONLY

Demographics:

Consumer's Name: Date of Birth (mo/day/year):
Consumer ID #: Telephone Number#:
Consumer's City/State:

Provider Name: Provider VO ID:
Provider Address (Street/City/State):
Contact Name:
Contact Phone #:

Responsible Party:

If consumer is a juvenile does the guardian listed have legal custody of the consumer?
 Yes No

If consumer is adult does the consumer have a legal guardian?
 Yes No

Parent/Guardian/Social Services/Juvenile Services Contact Information:

First Name: Last Name:
Address:
Phone Number:

Services Requested:

- Psychotherapy: (90801, 90804, 90806, 90807, 90847, 90849, 90853, 90857, 90876)
- Medication Management: (90801, 90805, 90807, 90862)

Units requested:

Requested Start Date for this Authorization (mo/day/year):

Required Data:

Race: White Asian American Indian Native Hawaiian or Other Pacific Islander Black or African American N/A

Ethnicity: Not Hispanic/Latino Hispanic/Latino Hispanic/Latino origin N/A

Education level: Preschool Headstart Regular Education Special Education Trade or Vocational or Technical School Not in school (< age 18) GED Program College (2 or 4 year program) Graduate School Other

Marital Status: Single Married Separated Divorced

Living Situation: Family Home Foster Home Treatment Foster Home Group Home On his/her own Other congregate Care Setting Jail/Correctional facility Homeless Shelter Other N/A

Employment status: Competitive Employment Supported Employment Unemployed-looking for work Retired Sheltered Employment Sheltered Workshop Homemaker Volunteer Disabled now- not in workforce Not seeking work N/A

Is consumer a Veteran? Yes No

If yes, what is most recent war served: Afghanistan Iraq Other

Is this a transition age consumer? Yes No

DSM-IV Diagnosis:

Axis I: 1) 2)
Axis II: 1) 2)
Axis III: 1) 2)
Axis IV:

Axis V: Current GAF: Highest GAF previous year:

Current Risks:

Risk Level Scale: 0=none, 1=mild, 2=moderate, ideation with either plan or history of attempts; 3=severe, ideation AND plan, with either intent or means; n/a=not assessed). Choose risk level for each category, and check all boxes that apply:

Risk to Self (SI):	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> n/a	with	<input type="checkbox"/> ideation	<input type="checkbox"/> intent	<input type="checkbox"/> plan	<input type="checkbox"/> means
Risk to Others (HI):	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> n/a	with	<input type="checkbox"/> ideation	<input type="checkbox"/> intent	<input type="checkbox"/> plan	<input type="checkbox"/> means

Current serious attempts: Yes No Choose: SI HI
 Prior serious attempts: Yes No Choose: SI HI
 Prior serious gestures: Yes No Choose: SI HI

Date of the most recent attempt or gesture (mo/day/yr):

CONSUMER'S NAME:

Current Impairments:

Scale: 0=none, 1=mild, 2=moderate, 3=severe, n/a = not assessed

0 1 2 3 n/a Mood disturbance (depression or mania)
0 1 2 3 n/a Anxiety
0 1 2 3 n/a Psychosis
0 1 2 3 n/a Thinking/cognition/memory
0 1 2 3 n/a Impulsive/reckless/aggressive
0 1 2 3 n/a Activities of Daily Living
0 1 2 3 n/a Weight loss assoc. w/behavioral Dx: gain loss n/a of
 Pounds in last 3 months: Current Weight: lbs
 Current Height ft inches

0 1 2 3 n/a Medical/physical condition(s)
0 1 2 3 n/a Substance abuse/dependence
0 1 2 3 n/a Job/school performance
0 1 2 3 n/a Social/marital/family problems
0 1 2 3 n/a Legal

Mental Health/Psychiatric Treatment History: (Please check all that apply)

None Unknown

Outpatient: If "Outpatient" is checked, please indicate:

Outcome: Unknown Improved No Change Worse
 Treatment compliance (non-med): Unknown Poor Fair Good

IOP/Partial: If "IOP/Partial" is checked, please indicate:

Outcome: Unknown Improved No Change Worse
 Treatment compliance (non-med): Unknown Poor Fair Good

Inpatient/Residential/Group Home: If "Inpatient/Residential/Group Home" is checked, please indicate:

Outcome: Unknown Improved No Change Worse
 Treatment compliance (non-med): Unknown Poor Fair Good
 Number of psychiatric hospitalizations in the past 12 months:

Substance abuse Treatment History: (Please check all that apply)

None Unknown

Outpatient. If "Outpatient" is checked, please indicate:

Outcome: Unknown Improved No Change Worse
 Treatment compliance (non-med): Unknown Poor Fair Good

IOP/Partial. If "IOP/Partial" is checked, please indicate:

Outcome: Unknown Improved No Change Worse
 Treatment compliance (non-med): Unknown Poor Fair Good

Inpatient/Residential. If "Inpatient/Residential" is checked, please indicate:

Outcome: Unknown Improved No Change Worse
 Treatment compliance (non-med): Unknown Poor Fair Good

Number of substance abuse hospitalizations in the past 12 months:

Other Treatment History: (Please check all that apply)

Criminal justice involvement in the last 12 months? Yes No
 Currently on probation? Yes No
 History of sexually inappropriate/aggressive behavior? Yes No
 History of fire setting in the last 12 months? Yes No
 Active gang involvement in the last 12 months? Yes No
 DSS/CPS involvement in the last 12 months? Yes No
 Victim of sexual or physical abuse? Yes No

Current psychotropic meds? Yes No If yes, please complete below:

Current Psychotropic Medications:

Meds.	Dose	Freq.	Usually Adherent? <input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

CONSUMER'S NAME:

Substance Use/Abuse: No Yes Unknown. *If yes, please complete below:*

Substance	Length Curr. use	Amount	Freq.	Date Last Used

Is family/couples therapy indicated? Yes No If yes, date of appointment (mo/day/year):

Involuntary Court Ordered Fixed length program (*specify length:*)
Frequency of program = per

Reason for Continued Treatment: remains symptomatic conduct family therapy
 stabilize medications has not achieved treatment goals finalize discharge plan other:

Agencies Involved

Does member have any state agency affiliation? Yes No Unknown

- Protective services (Adult or child)
- Local Department of Social Services (DSS)
- Homeless Services
- Parole and Probation
- County Funded Mental Health
- Department of Juvenile Services (DJS)
- Division of Rehabilitation Services
- Other (self-rehab, supported groups, etc.)

Description of Current Agency Services/Contact Information:

History of Services

TREATMENT/REHABILITATION/SERVICE PLAN GOALS

I am treating this consumer according to VO treatment guidelines Yes No

I am coordinating this consumer's case with other behavior/medical providers as appropriate Yes No

The treatment plan was developed with the consumer and has measurable time limited goals Yes No

Consumer/Guardian involved in Treatment plan? Yes No

Was Consumer given a copy of this treatment plan? Yes No

Date of Plan

Long Term Goals:

CONSUMER'S NAME:

Strengths and Skills

Consumer Expectations and Responsibilities

Identify Consumer's Supports

Individual's Hope for Recovery (in consumer's own words)

Goal 1:
Short Term Goal Target Date

Short Term Goal #1

Intervention

Update on Progress

Goal 2:
Short Term Goal Target Date

Short Term Goal #2

Interventions

Update on Progress

CONSUMER'S NAME:

**Goal 3:
Short Term Goal Target Date**

Short Term Goal #3

Interventions

Update on Progress

**Goal 4:
Short Term Goal Target Date**

Short Term Goal #4

Interventions

Update on Progress

Discharge Plan

Expected Discharge Date:

Responsible Staff:

- 1.
- 2.
- 3.
- 4.

Signature of person completing this form:

Date (mo/day/year)