



# Outpatient Review Form - Kentucky

Please Fax to Beacon at 1-800-441-2281

Health Plan

☐ Passport

☐ Humana/CareSource

## Member Information *(verify eligibility before rendering services)*

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

Member ID: \_\_\_\_\_ DOB: \_\_\_\_\_

Request is:

☐ Initial

☐ Concurrent

## Current Psychotropic Medications

Are Psychotropic Meds being prescribed? ☐ Yes ☐ No ☐ Unknown

If yes, prescribed by : ☐ MD ☐ RN, CS/NP ☐ PCP

Prescriber: \_\_\_\_\_

List of Meds: \_\_\_\_\_

Is Member currently compliant with meds? ☐ Yes ☐ No

Is the Member court order to treatment? ☐ Yes ☐ No

Is the Member SPMI or SED? ☐ Yes ☐ No

## DSM-IV Diagnosis

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

GAF (0-100): \_\_\_\_\_ HGAF: \_\_\_\_\_

Have you communicated with member's PCP in past 12 months?

☐ Yes ☐ No With the prescriber? ☐ Yes ☐ No ☐ N/A

## Treatment Status

(Please rate the member's response to treatment since last review or since start of treatment if this is first report.)

Behavioral Symptoms that are focus of treatment:

☐ Much Worse ☐ Slightly Worse ☐ No Changes ☐ Slight Improvement

☐ Major Improvement

Ability to perform work/school/household tasks:

☐ Much Worse ☐ Slightly Worse ☐ No Changes ☐ Slight Improvement

☐ Major Improvement

## Provider Information

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

Provider ID: \_\_\_\_\_

Clinician Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

Fax#: \_\_\_\_\_

☐ IMPACT Plus Provider

## Current Risk Indicators (check all that apply)

☐ Current substance abuse ☐ Fire setting

☐ Caring for ill family member ☐ Impulsive behavior

☐ Self-mutilation/cutting ☐ Assaultive behavior

☐ Sexually offending behavior ☐ Psychotic symptoms

☐ Current family violence (abuse, domestic)

☐ Coping with significant loss (job, relationship, financial)

☐ Other: \_\_\_\_\_

## Risk Assessment (check all that apply)

### Suicidal Tendency:

☐ Not present ☐ ideation ☐ plan ☐ means ☐ prior attempt (date): \_\_\_\_\_

### Homicidal Tendency:

☐ Not present ☐ ideation ☐ plan ☐ means ☐ prior attempt (date): \_\_\_\_\_

Rate member's level of psychological distress:

☐ 1 (minimal) ☐ 2 (mild) ☐ 3 (moderate) ☐ marked ☐ severe

Current Risk of Psychiatric Hospitalization:

☐ 1 (low) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (high). If 3 or higher, explain: \_\_\_\_\_

Status of the three most significant targeted goals since treatment initiation using the following scale:

N = New Goal 1 = Much Worse 2 = Somewhat Worse 3 = No Change 4 = Slight Improvement

5 = Major Improvement R = Resolved

Goal	Modality (Indiv/Grp/Hm/Collateral)	Progress (since tx initiation – indicate rating #
1.		
2.		
3.		

Previous Treatment: Please indicate total number in last 12 months:			
	<b>IP Admits</b>	<b>OP Visits</b>	<b>PHP/IOP/Day Tx</b>
Mental Health			
Substance Abuse			

**Request for Services- Traditional Outpatient:**

Service	# of Units	Start Date	Anticipated Completion Date	Frequency of sessions:
Diagnostic Interview				
Individual Therapy				
Individual w/ med management				
Family Therapy				

**Request for Services- Community Support Services – IF UNABLE TO USE eSERVICES**

Service	# of Units	Start Date	Anticipated Completion Date	Frequency of sessions:
Therapeutic Rehabilitation/Day Tx				
Therapeutic Behavioral Services (under 21)				
Targeted Case Management				
Personal Care Services				
Home Visit/Wrap				
Community Psychiatric Support				

**Request for Services- IMPACT Plus ONLY – please submit Collaborative Service Plan along with request for services**

Service	# of Units	Start Date	Sessions over the next (30, 60 90 days)	Provider Rendering Service
Targeted Care Management				
Behavioral Health Evaluation				
Therapeutic Child Support (professional)				
Therapeutic Child Support (para-professional)				
Parent-to-Parent Service				
After School Program				
Summer School Program				
Intensive Outpatient				
Day Treatment				
Partial Hospitalization				
Individual Therapy				
Individual Therapy with MD				
Individual OR Collateral Therapy (for professionals under supervision)				
Group Therapy				
Collateral Service				