



PCHP TREATMENT PLAN

PATIENT INFORMATION

Patient's Last Name: _____ First: _____
 Insured ID Number: _____ Patient's Age: _____

PRACTITIONER INFORMATION

Practitioner's Name: _____
 Number of Sessions Completed this Year: _____ Date of Most Recent Session: ____ / ____ / ____
 Date Patient First Seen for this Episode of Treatment: ____ / ____ / ____
 Is the patient on short-term or long-term disability? Yes No
 Have you communicated with PCP/other relevant health care practitioners about treatment? Yes No

DIAGNOSIS

AXIS I: Dx Code: _____ - _____ AXIS II: Dx Code: _____ - _____
 AXIS III: _____
 AXIS IV: Economic Problems Problems Accessing Health Services Housing Problems Occupational Problems
 Problems Related to Social Environment/School Problems Related to Interactions with Legal/Criminal
 Other Psychosocial Problems__
 AXIS V: GAF Score: Highest Past Year: ____ At First Session: ____ Current: ____

CURRENT MEDICATIONS

Current Medications: _____
 Prescribed By: _____

CURRENT SYMPTOM CHECKLIST

<input type="checkbox"/> Suicidal	<input type="checkbox"/> Coping with Pain	<input type="checkbox"/> Lack of Insight	<input type="checkbox"/> Impaired Attention/ Concentration	<input type="checkbox"/> Impaired Social Relationships
<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Rage/Anger	<input type="checkbox"/> Oppositional	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Alcohol Abuse / Dependence
<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Self-harm	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Past History Sexual/Physical Abuse	<input type="checkbox"/> Other Substance Abuse
<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Anhedonia	<input type="checkbox"/> Sleep Disturbance/Fatigue	<input type="checkbox"/> Paranoia/Suspicious	<input type="checkbox"/> Other _____
<input type="checkbox"/> Irritability	<input type="checkbox"/> Eating Disturbance	<input type="checkbox"/> Distorted Thinking	<input type="checkbox"/> Hallucinations/Delusions	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Memory Problems		

Treatment Goals:
 1. _____
 2. _____
 3. _____

Which of the following best indicates progress? Check all that apply:
 Compliant Non-compliant In Crisis Other: _____
 At-risk Progressing Not progressing _____

CONCURRENT AUTHORIZATION REQUEST (number of sessions)

Length of Time for Each Session:	3 months	6 months
90805	<input type="checkbox"/>	<input type="checkbox"/>
90806	<input type="checkbox"/>	<input type="checkbox"/>
90806	<input type="checkbox"/>	<input type="checkbox"/>
Other CPT Code: _____	<input type="checkbox"/>	<input type="checkbox"/>

CPT Session Requested: _____ Number of Sessions Requested: _____
 Anticipated Session Frequency: Weekly Twice Monthly Monthly Other _____

Comments: _____

Signature: _____ Date: ____ / ____ / ____

Note: Approval of treatment plan does not guarantee payment.