

University of Wisconsin Behavioral Health Psychiatrist Outpatient Treatment Request

Date Faxed: _____

Initial Request

Physicians Plus

Today's Date: _____

Follow-up Request

Unity

Last date patient seen by you: _____

Frequency of past visits: _____

Patient's Name: _____ DOB: _____ Member #: _____

Provider's Name: _____ Clinic Name: _____

Provider Number: _____ Provider Phone Number: _____ Provider Fax Number: _____

Diagnosis: (Rank Axis I diagnoses according to treatment focus. Use DSM IV Codes where applicable.)

| | | | | |
|----------------|-----------------|------------------|----------------------------------|--|
| AXIS I: | AXIS II: | AXIS III: | AXIS IV: (list stressors) | AXIS V (GAF) |
| _____ | _____ | _____ | _____ | _____ /_____ (current/past year) |

SYMPTOMS (check all that apply)

- | | | | | |
|---|-------------------------------------|---|---|--|
| <input type="checkbox"/> Change of Appetite | <input type="checkbox"/> Irritable | <input type="checkbox"/> Psychotic Symptoms | <input type="checkbox"/> Work/School Performance Affected | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Change in Sleeping | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Change in Concentration | <input type="checkbox"/> Suicidal/Self-Destructive |
| <input type="checkbox"/> Abnormal Mood | <input type="checkbox"/> Depression | <input type="checkbox"/> Thought Disorder | <input type="checkbox"/> Diminished Pleasure Capacity | |
| <input type="checkbox"/> AODA (specify) _____ | | <input type="checkbox"/> Other: (specify) _____ | | |

Medication Management:

Will you do?

YES NO

Will PCP do?

YES NO

Medication Only

Stable

Titrating

Specify

Medications: _____

Will you eventually be referring medication management to PCP? Immediately Eventually

Recommending Psychotherapy ?

Yes No

Current Therapist ?

Yes No

If yes, what is/should be focus of treatment? _____

Will you be doing ? Yes No

If you are recommending a specific PPIC or Unity provider, please identify: _____

Additional information: _____

PROVIDER REQUESTED SERVICES

| Intervention | No. of Visits | Begin Date | End Date | Other (specify): |
|---------------|---------------|------------|----------|------------------|
| Medications | _____ | _____ | _____ | _____ |
| Psychotherapy | _____ | _____ | _____ | _____ |

Ancillary services recommended not requiring precertification: _____

Name of

PCP: _____ Release to PCP: Yes No PCP Contacted: Yes No

If follow-up treatment plan, **Patient Signature:** _____ Date: _____

UWBH Authorization & Communication

| Axis I Dx | No. of Visits | Begin Date | End Date | Authorization No. | Consultant | Date |
|-----------|---------------|------------|----------|-------------------|------------|-------|
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |

Comments: _____