

Date Faxed: \_\_\_\_\_  
Fax: (608) 238-1026

# University of Wisconsin Behavioral Health Outpatient Treatment Plan Request

Phone: (800) 683-2300  
(608) 233-3575

Physicians Plus

Unity

Unity Badgercare

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Member No: \_\_\_\_\_ DOB: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Panel Provider:  Yes  No Provider No: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Phone No: \_\_\_\_\_ Fax No: \_\_\_\_\_

Date of Assessment: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Frequency of visits: \_\_\_\_\_

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)  
(Treatment onset/Current)

/

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Functional Impairments Scale: (Mild) 1 2 3 4 5 (Incapacitating)

Personal/Individual \_\_\_\_\_ Family/Significant other \_\_\_\_\_ Social/Interpersonal \_\_\_\_\_ Work/School/other \_\_\_\_\_ AODA Issues \_\_\_\_\_

Functional Impairments (observable & specific): \_\_\_\_\_

Outcome Goals Achieved to Date: \_\_\_\_\_

Remaining Goals: \_\_\_\_\_

Number of Visits Requested Individual RX: \_\_\_\_\_ Conjoint RX: \_\_\_\_\_ Family RX: \_\_\_\_\_ Group RX: \_\_\_\_\_

Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Outcomes Score: \_\_\_\_\_

Release to PCP:  Yes  No | PCP Contacted:  Yes  No

Other Providers Involved? (Identify): \_\_\_\_\_

Are there other family members receiving treatment by a P+ or Unity provider?  Yes  No

If yes, please identify provider(s): \_\_\_\_\_

If follow-up treatment plan, Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE. FOR UWBH AUTHORIZATION AND COMMUNICATION.**

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

Comments: \_\_\_\_\_