Mental Health Outpatient Treatment Plan

PacificSource

Please fax to: (541) 225-3667

Or mail to:
PacificSource
Attn: Health Services
PO Box 7068
Springfield OR 97475-0068

Please complete the *entire* form and fax or mail it to us. Missing information will delay the review process. If you have any questions or have a special request, please feel free to contact our Behavioral Health Team at (888) 691-8209.

▼ PATIENT

Last name: _____ First name: _____

Date of birth: _____ Member ID number: _____

▼ CONTACT/PROVIDER INFORMATION

Contact person:

Name: _____ Date: _____

Phone: _____ Extension: _____ Fax: _____

Treating Provider:

Name: _____ License type: _____

Phone: _____ Extension: _____ Fax: _____

Mailing address: _____

City/State/Zip: _____ TIN: _____

▼ TREATMENT INFORMATION

Diagnosis code and description: _____

Number of visits requested: _____ **Requested time frame:** From: _____ To: _____

Note: Preferred time frame per treatment plan is six months. If you need more time, please note reasons in the Comments section on this form or contact a Behavioral Health Team Case Manager.

▼ CLINICAL DATA (to support above diagnosis and treatment being provided)

Current symptoms:

- ☐ Appetite (up/down)
- ☐ Acting out at school/home
- ☐ Cognitive impairment
- ☐ Delusional ideas
- ☐ Depressed mood
- ☐ Disorganized/bizarre thoughts
- ☐ Dissociation
- ☐ Elevated or irritable mood
- ☐ Excessive fear or worry
- ☐ Feeling worthless/guilty
- ☐ Hallucinations
- ☐ Impaired judgment/insight
- ☐ Impairment in concentration
- ☐ Impulsivity
- ☐ Loss of interest
- ☐ Physical activity (up/down)
- ☐ Racing thoughts
- ☐ Recurring unwanted thoughts
- ☐ Reliving traumatic events
- ☐ Repetitive Behaviors
- ☐ Self-harm behavior
- ☐ Sleep (up/down)
- ☐ Substance use/abuse
- ☐ Suicidal/Homicidal thinking

Functional domains that are currently impaired and are treatment targets:

- ☐ Activities of daily living
- ☐ Disability
- ☐ Finances
- ☐ Friendships/peers
- ☐ Job/School performance
- ☐ Marriage/Relationships/Family
- ☐ Physical health
- ☐ Pleasurable activities
- ☐ Sexual functioning
- ☐ Sleep habits

Continued on next page

▼ CLINICAL DATA (continued)

Describe the behaviors and/or symptoms that address areas of impairment and support the continued need for treatment. For eating disorder diagnosis, please include weight, height, and BMI:

List the current treatment goals:

Describe the progress to date and the interventions being used:

Is your patient currently taking psychotropic medication? ☐ Yes ☐ No ☐ Not sure

List current medications: _____

Type of prescribing clinician: ☐ PCP ☐ PMHNP ☐ Psychiatrist ☐ Other: _____

Are you coordinating with the prescriber? ☐ Yes ☐ No

Is your patient involved with other types of providers/community services? ☐ Yes ☐ No

Describe coordination of care:

Comments: