Outpatient Information for Residential Requests

Provider Name: _____ Contact number: _____
Beneficary ID: _____Last name: _____ First name: _____
Date form completed: _____

1. Axis I Psychiatric diagnosis ***(include all)*** during outpatient OP treatment: _____
2. Problems/Behaviors addressed in treatment plan: _____
3. What progress/improvements observed (explain)? _____
4. Client/family strength (include natural supports): _____
5. List all agencies contacts that are currently involved in the client's care ***(please include phone number)***: _____
6. Date client last attended individual therapy session: _____
   a. Are sessions routinely missed? ☐ Yes ☐ No
7. Date client and family attended last family therapy session: _____
   a. Is family active and involved? ☐ Yes ☐ No
8. Date client attended last medication management session: _____
   a. Are meds being refused? ☐ Yes ☐ No
9. How often is client seen for medication management? _____
10. Was Crisis Interventions provided within the last 6 months to client or family? _____
11. Was there a positive outcome? _____ ***(Describe)*** _____
12. Frequency of:
    a) Individual therapy from LMHP: _____ Total # of sessions within last 90 days _____
    b) Family therapy sessions from LMHP: _____ Total # of sessions within last 90 days _____
13. Other OP services received ***(frequency &type i.e. case management, rehab day, community supports)***: _____

14. Describe the current symptoms client is displaying in the school, community and at home that cannot be managed safely in an outpatient treatment setting: ***(specify if behavior only occurs in a specific setting)***: _____
15. List type(s) and date(s) of serious physically aggressive or destructive acts committed by the client in the last 30 days: _____
16. Legal charges? _____ ***(Describe (reason/type)***? _____
17. List the dates and length of stay of acute hospitalizations in last 12 months: _____
18. What will occur in the residential setting to support client return to family/community? _____

OP Clinic name: _____ City/Location: _____

Name/Signature of Therapist: _____ Date: _____

(Additional documents may be submitted to support the request)