



Behavioral Health Treatment Plan Form
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This form is to be used when requesting continued treatment for a patient after an initial number of authorized sessions. Anthem Blue Cross products and services include, but are not limited to: Prudent Buyer, the Anthem Blue Cross Behavioral Health Program, and other affiliated companies' programs.

Patient Name (Last, First) :	Age:	Date:
Authorization Number:	Subscriber Social Security #:	

Diagnosis:

Primary focus of treatment is: Psychiatric Substance Abuse

Specify Code:

Axis I: _____ Axis II: _____ Axis III: _____

Axis IV: (Check below those which *currently* apply):

Problems with primary support group Educational problems Occupational problems Problems related to social environment

Housing problems Economic problems Problems related to interaction with legal system / crime SED / 2726

Other (describe): _____

Axis V Current: _____ Highest past year: _____

Risk Assessment (Check those which *currently* apply):

Risk of Suicide: Ideation Plan Means History of prior attempts

Risk of Violence: Ideation Plan Means History of prior attempts

Risk of Grave Disability – Child Adolescents (Check those that apply):

Minor is at risk for removal from the home or has already been removed from the home

Minor cannot use food, clothing, or shelter as provided by others

Treatment History (Check all that apply): None Psychiatric Substance Abuse

Outpatient Treatment within: 6 months 1 year 2-5 years more than 5 years ago

Partial Hospitalization or Day Care within: 6 months 1 year 2-5 years

Residential Treatment within: 6 months 1 year 2-5 years

Inpatient Treatment within: 6 months 1 year 2-5 years

Treatment Progress:

Number of sessions to date: _____ Number of sessions to complete entire episode of treatment: _____

Has termination and/or discharge been discussed with client? Yes No

Is the patient actively participating in treatment on a regular basis? Yes No

Treatment Approach (Check all that apply):

Modality used: Individual psychotherapy Conjoint psychotherapy Family therapy

Group therapy Medication management

Are there other forms of treatment or community services being utilized: Yes No If yes, please specify: _____

Symptoms:

Check below all that *currently* apply:

Anxiousness Appetite disturbance Decreased energy Delusions Depressed moods Dissociation

Elevated mood Hallucinations Hyperactivity Hopelessness Impaired memory / concentration

Impulsivity Irritability Mania Mood lability Obsessions / compulsions Oppositionality

Panic attacks Paranoia Self-injurious bx Sleep dist. Somatic complaints Worthlessness

Substance Use / Abuse Active In Remission

Without treatments symptoms would likely persist for: 0-6 months 6-12 months More than 12 months

Symptoms have been present for as long as: 0-6 months 6-12 months More than 12 months

Medications:

Has patient been evaluated for medication? Yes No Is patient on medication? Yes No Client refuses

If yes, is the patient compliant with medication? Yes No Prescribing physician: PCP Psychiatrist Other

Name of prescribing physician: _____ Telephone Number: _____

Have you contacted the prescribing provider to coordinate care? Yes No

If not, please explain: Patient refused coordination of care Attempt made, no response

Plan to initiate coordination by _____

Name of Medication	Current Dosage	Current Frequency	Start Date

Print Provider Name:	Date:
Provider Signature:	Telephone: