SWSCHP
State-Wide Schools Cooperative Health Plan

Amalgamated Medical Care Management
Quality Clinical Advice & Care

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Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

Treatment began on: ____/____/____ Treatment resumed on: ____/____/____

Patient ID Number: _____
Date of Birth: _____
Patient Name: _____

Facility/Practice Name: _____
Provider Name: _____
Address: _____
City, State, ZIP: _____
Phone: _____
NPI #: _____
TAX ID #: _____

FUNCTIONAL IMPAIRMENT

	Mild	Mod	Severe
ADLs	❍	❍	❍
Physical Health	❍	❍	❍
Family/Relationships	❍	❍	❍
Work/School	❍	❍	❍
Substance Abuse	❍	❍	❍

Brief Description of Substance Abuse:

ICD DIAGNOSIS / CPT

_____
_____
_____

PSYCHOTROPIC MEDICATIONS

Prescribed by ❍ PCP ❍ Psychiatrist ❍ APRN
1: _____
2: _____
3: _____

If affective or psychotic disorder is presented and no medications are prescribed, please explain:

SYMPTOMS

	Mild	Mod	Severe
Anxiety	❍	❍	❍
Decreased Energy	❍	❍	❍
Delusions	❍	❍	❍
Depressed Mood	❍	❍	❍
Hallucinations	❍	❍	❍
Hopelessness	❍	❍	❍
Hyperactivity	❍	❍	❍
Inattention	❍	❍	❍
Irritability	❍	❍	❍
Impulsivity	❍	❍	❍
Mood Instability	❍	❍	❍
Obsessive/Compulsive	❍	❍	❍
Other Psychiatric Symptom	❍	❍	❍
Panic Attacks	❍	❍	❍
Sleep Disturbance	❍	❍	❍

TREATMENT GOALS

Desired Measurable Outcome #1

Desired Measurable Outcome #2

LEVEL OF IMPROVEMENT TO DATE

❍ Maintenance to Chronic Condition
❍ Minor ❍ Moderate ❍ Major
❍ No Progress

SESSIONS

Total # _____ sessions used since treatment began or resumed
____/____/____

Total # _____ sessions used since last approval
Date of last approval ____/____/____

REQUESTED TYPE OF SERVICES:

❍ Outpatient Mental Health
❍ Outpatient Alcohol/Substance Abuse
❍ Intensive Outpatient Treatment (Mental Health)
❍ Intensive Outpatient Treatment (Alcohol/Substance Abuse)

RISK ASSESSMENT

❍ **Suicidal:**
❍ Ideation ❍ Planned ❍ Imminent Intent
❍ History of Self-Harming Behavior

❍ **Homicidal:**
❍ Ideation ❍ Planned ❍ Imminent Intent
❍ History of Self-Harming Behavior

MODALITIES

❍ Individual
❍ Family/Couple (circle)
❍ Group
❍ Medication Management

NUMBER OF VISITS BEING REQUESTED AT THIS TIME

Requesting #_____ visits from____/____/____ to ____/____/____
Requesting #_____ visits from____/____/____ to ____/____/____
Requesting #_____ visits from____/____/____ to ____/____/____
Requesting #_____ visits from____/____/____ to ____/____/____

PROJECTED ESTIMATED LENGTH OF TREATMENT

❍ Less than 1 month ❍ 1-2 months
❍ 4-6 months ❍ 6-12 months
❍ Other: _____

TREATMENT HISTORY

❍ **In-patient** ❍ Within the past year ❍ 1-3 years ago ❍ More than 3 years ago
❍ **Out-patient** ❍ Within the past year ❍ 1-3 years ago ❍ More than 3 years ago

COMMENTS

_____
Provider Signature (My signature confirms I am providing above services) Date: ____/____/____
Provider Credentials:_____ License:_____