INTEGRATED BEHAVIORAL HEALTH
REQUEST FOR CONTINUED MENTAL HEALTH TREATMENT

Insured SS#: _____

Patient Name: _____ DOB: _____ Sex: M F Report Date: _____

Insured Name: _____ Employer: _____

Practitioner Name: _____ License #: _____ License Type: _____

_____ ( )
Address City State Zip Phone

1. **TREATMENT HISTORY** (For current episode)
   a. Date began this treatment: _____
   b. Date of last treatment certification request: _____
   c. GAF at onset of treatment: _____

RECEIVED BY IBH

(FOR OFFICE USE ONLY)

2. **DSM IV Dx:** (All 5 Axes must be completed)

	Code	**Name**
Axis I (1):	_____	_____
Axis II:	_____	_____
Axis III:	_____	_____

Axis IV (Stressors): _____
Axis V: Current GAF: _____
Highest GAF Past Year: _____

3. **SYMPTOMS** (Current symptoms that justify diagnosis.):

4. **REQUESTED SERVICES**

PRACTITIONER	**Sessions to Date**	**Requested Sessions**	**Frequency** ***(circle week or month)***	**Requested Cert Period (Dates) From**	**To**
Individual Therapy	_____	_____	(at_____/week/month)	_____	_____
Group Therapy	_____	_____	(at_____/week/month)	_____	_____
Family Therapy	_____	_____	(at_____/week/month)	_____	_____
Multifamily Therapy	_____	_____	(at_____/week/month)	_____	_____
Biofeedback	_____	_____	(at_____/week/month)	_____	_____
Pharmaco Therapy Mgmt.	_____	_____	(at_____/week/month)	_____	_____

Psychological Testing: Question to be answered: _____
(All psychological testing must be pre-certified by a phone contact with a care manager.)

Tests Proposed: _____

Patient: _____

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5. **PROGRESS** (Review of progress since last report):

6. **MEDICATIONS** (Please explain any change in medications since previous report.)

Meds Discontinued	Meds Started		Meds Continued	
Name	Name	Dosage/Frequency	Name	Dosage/Frequency

7. Has there been an identifiable stress or trauma in the patient's life since you began this level of treatment?
___ No ___ Yes; Explain:

8. Has there been a recent significant change in functioning? Explain:
___ No ___ Yes (___ deterioration ___ improvement)

9.

TREATMENT GOALS (specific and measurable)	**TREATMENT STRATEGIES FOR EACH GOAL**
1. _____	_____
Changes Noted: _____	_____
2. _____	_____
Changes Noted: _____	_____
3. _____	_____
Changes Noted: _____	_____
4. _____	_____
Changes Noted: _____	_____
5. _____	_____
Changes Noted: _____	_____
6. _____	_____
Changes Noted: _____	_____

Patient: _____

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(NOTE: <u>All</u> services must be pre-certified)

10. a. Will any other providers be involved in treatment? ___ No ___ Yes

b. If yes, please indicate Provider Name: _____
(Please Print)

c. License #: _____ License Type: ☐ M.D. ☐ Ph.D./Psy.D. ☐ MFT/LCSW

d. Services to be provided: ☐ Medications ☐ Marital/Family Therapy ☐ Individual Therapy ☐ Evaluation/Assessment
☐ Group ☐ Other _____

e. Document date of last contact with this provider:

f. Is this provider an IBH Network Preferred Provider? ___ No ___ Yes

11. **Termination Plan**

(To be completed by primary provider at first Request for Continued Treatment and then updated each subsequent Request)

a. Anticipated date of termination session: _____

b. Adjunctive referrals to be made (or in place) and when:

(To be completed by primary provider towards the end of the middle stage of therapy or upon request)

c. Percentage of goals of therapy completed (to date):

d. Goals of therapy not completed are:

e. Recommendations/Comments:

f. Prognosis *(based on what indicators?)*: ☐ Good ☐ Fair ☐ Poor

PROVIDER NAME *(please print)*: _____

I acknowledge that I am personally providing the treatment services requested herein (with the exception of those stated in item 10).

_____ _____
Provider Signature **Date**

Return Address: **Integrated Behavioral Health**
Care Management Service
P. O. Box 30018
Laguna Niguel, CA 92607-0018
or
Confidential Fax: **(714) 556-5430**