



Behavioral Health Outpatient and/or Chemical Dependency Interval Treatment Plan

Provider Name: _____		Specialty: <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> PsyD <input type="checkbox"/> LCSW <input type="checkbox"/> CSAC <input type="checkbox"/> MA/LMFT <input type="checkbox"/> APRN/NP	
If affiliated with a clinic/facility, please indicate facility name: _____		Office Contact Person: _____	
Phone #: _____	Fax#: _____	Date: _____	

MEMBER INFORMATION

NAME: _____	Member ID#: _____	DOB: _____	Age: _____
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CLINICAL INFORMATION

Axis I: _____ _____ Axis II: _____ Axis III: _____ Axis IV: _____ Axis V (GAF) Current _____ Past Year _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; padding: 2px;">SEVERITY OF SYMPTOMS NOW: (If Dual Dx use CD scale)</th> <th style="text-align: center; padding: 2px;">NONE</th> <th style="text-align: center; padding: 2px;">LOW</th> <th style="text-align: center; padding: 2px;">MODERATE</th> <th style="text-align: center; padding: 2px;">HIGH</th> </tr> <tr> <td style="padding: 2px;">1. Physical/Medical SX that complicate TX</td> <td style="text-align: center; padding: 2px;">0</td> <td style="text-align: center; padding: 2px;">1</td> <td style="text-align: center; padding: 2px;">2</td> <td style="text-align: center; padding: 2px;">3 4</td> </tr> <tr> <td style="padding: 2px;">2. At risk for harm to self or others</td> <td style="text-align: center; padding: 2px;">0</td> <td style="text-align: center; padding: 2px;">1</td> <td style="text-align: center; padding: 2px;">2</td> <td style="text-align: center; padding: 2px;">3 4</td> </tr> <tr> <td style="padding: 2px;">3. Impaired: Judgment, communication, perform work or ADLs</td> <td style="text-align: center; padding: 2px;">0</td> <td style="text-align: center; padding: 2px;">1</td> <td style="text-align: center; padding: 2px;">2</td> <td style="text-align: center; padding: 2px;">3 4</td> </tr> <tr> <td style="padding: 2px;">4. Treatment motivation</td> <td style="text-align: center; padding: 2px;">0</td> <td style="text-align: center; padding: 2px;">1</td> <td style="text-align: center; padding: 2px;">2</td> <td style="text-align: center; padding: 2px;">3 4</td> </tr> <tr> <td style="padding: 2px;">5. Alcohol/Substance Abuse</td> <td style="text-align: center; padding: 2px;">0</td> <td style="text-align: center; padding: 2px;">1</td> <td style="text-align: center; padding: 2px;">2</td> <td style="text-align: center; padding: 2px;">3 4</td> </tr> <tr> <td style="padding: 2px;">Date of last use: _____</td> <td colspan="4"></td> </tr> </table>	SEVERITY OF SYMPTOMS NOW: (If Dual Dx use CD scale)	NONE	LOW	MODERATE	HIGH	1. Physical/Medical SX that complicate TX	0	1	2	3 4	2. At risk for harm to self or others	0	1	2	3 4	3. Impaired: Judgment, communication, perform work or ADLs	0	1	2	3 4	4. Treatment motivation	0	1	2	3 4	5. Alcohol/Substance Abuse	0	1	2	3 4	Date of last use: _____				
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Current Psychiatric Medication

MEDICATION	SIG	START DATE/PRESCRIBER

If C.D.:

A.S.A.M. Dimension	Low	Med	High
Acute intoxication/withdrawal potential			
Biomedical conditions/problems			
Emotional, behavioral, or cognitive conditions or complications			
Readiness for change			
Relapse potential/recidivism			
Recovery environment/family support			

Clinical Summary, Patient Progress or Compliance (If Initial Plan include Prior Tx Hx): _____

Plan, Expected Frequency, Approaches and Expected Length of Treatment: _____

Family/Social/Community Support: _____

Level of Care Requested: (check): Outpatient Partial IOP LIOP OPS Methadone

How many hours have you seen the patient? To date: _____ Fiscal Year: _____ Date of first service: _____

Treatment Modality: (Check): Individual Group Family Med. Mgmt. Interpreter: (language) _____

Requested # of visits: _____ **Begin Date:** _____ **End Date:** _____ **QUEST ONLY: Potential SMI/SED?** Yes No

Provider Signature: _____ Date: _____

Patient Signature: _____ Date: _____

By Signing this Treatment Plan, You have consented to release clinical information to AlohaCare and have been informed by your provider (co-signer) the parameters of disclosure under CFR 42 part 2 for Substance Abuse Treatment and both State/Federal Laws regarding disclosure for mental health services as well.

FOR ALOHACARE USE ONLY: QU ACA ACAP AUTH #: _____ Benefits Used: _____

Approved: _____ Approve Dt: _____ Deny Dt: _____ Reason: _____ Init/Dt: _____