Outpatient Treatment Progress Report

To request further certifications, please fax or mail to: **United Behavioral Health MN-CMC**
MR:MN010-S155, P.O. Box 1459, Minneapolis, MN 55440-1459
Phone: 1-800-848-8327 (Toll Free Minnesota Location) or FAX (763)732-6910

MEMBER INFORMATION

Member Name*: (*First & Last*)	Member ID#:	Date of Birth*

Member Address: (City/State)_____
Member Home Phone:
Member Work Phone:

Print clearly
Provider Name: _____Degree _____
Phone :_____Address: _____

Number of Sessions to date: _____Frequency _____
Date 1st Visit _____ Date Last Visit _____
Release of information for UBH signed: __Yes __No
Release of information for PCP signed: ☐ Yes ☐ No
__TX Plan or Summary sent to patient's PCP
__Member/ Parent/Guardian refused consent for release to PCP
__Member states they have no PCP

If Child/Adolescent: Is Family Involved? ☐ Yes ☐ No
Prior Treatment- Episodes in past year:
MH # of times Outpatient_____Inpatient____PHP____IOP_____
CD: # of times Outpatient_____Inpatient____PHP____IOP_____
Outcome: AMA discharge _____Completed Treatment/still using_____
Completed Treatment/Sober _____Active in CD Support Group? __Yes __ No

Current Symptoms:

Mood: ☐ Sad, ☐ Elated, ☐ Hopeless, ☐ Low Energy, ☐ Poor Concentration, ☐ Angry, ☐ Appropriate, ☐ No Problem, ☐ Other_____
Anxiety: ☐ Worry, ☐ Panic, ☐ Fearfulness, ☐ Compulsive, ☐ None, ☐ Other_____
Thought: ☐ Delusions, ☐ Hallucinations, ☐ Disorganized Speech, ☐ Obsessive, ☐ Distractible, ☐ No Problems ☐ Other_____
Behavior: ☐ Aggressive, ☐ Truant, ☐ Runaway, ☐ Disorganized behavior, ☐ Compulsive, ☐ Hyperactive ☐ Other_____
Sleep Problems, Describe:_____ **Appetite Problems, Describe:** _____

DIAGNOSIS ★***TIP:*** Use ***DSM-IV*** Codes; include all Axes.

Axis I - Primary _____ **Axis II** -_____
Secondary _____ **Axis III** - _____

Axis IV
☐ Economic problems ☐ Problems with accessing health services
☐ Housing problems ☐ Problems related to interactions with legal/criminal system
☐ Occupational problems ☐ Problems related to social environment/school
☐ Other psychosocial problems

Axis V (*GAF*) Current _____
Highest in last 12 months_____ **Target Problems/ Symptoms**: _____
_____
_____

RISK ASSESSMENT

Suicidality:	**Homicidality:**	**Hx Substance**
☐ None	☐ None	Abuse/Dependence:
☐ Ideation	☐ Ideation	Assessed __ Yes __ No
☐ Plan	☐ Plan	Problem ? ☐ Yes ☐ No
☐ Intent w/o means	☐ Intent w/o means	If yes, drugs of choice:
☐ Intent with means	☐ Intent with means	_____
☐ Ideation in past yr	☐ Ideation in past yr	☐ Current Abuse/Dependence
☐ Attempt in past yr		☐ By Family/Significant Other

☐ Family/peer history of completed suicide

If risk exists: Client is able to contract not to harm
☐ Self ☐ Others

Other Risk Factors:
☐ Hx Physical/Sexual Abuse
☐ Child/Elder neglect
☐ Anorexia ☐ Bulimia

Member has been evaluated for psychiatric meds? ☐ Yes ☐ No **Prescribing MD:** ☐ Psychiatrist Name: ☐ PCP Name:

CURRENT MEDICATIONS Include all meds psychiatric and medical

Drug	Current Dose	Duration	Drug	Current Dose	Duration

Progress Update
❑ Compliant, Progressing and Improving –Needs more sessions
❑ Compliant, Progressing and Improving- Plan for discharge When?_____
❑ Compliant, Not Progressing or Improving – Needs Med referral_____
❑ Not Compliant, but at risk How addressed?_____
❑ Not Compliant, Needs Referral for other Services/ Therapy

If Patient needs referral
❑ Have you made the referral? ☐ Yes ☐ No
❑ Can UBH help you with the referral?
❑ Would like to consult with a UBH clinician? MSW MA PhD MD

Expected Outcome and Prognosis
☐ Return to normal functioning
☐ Expect improvement, anticipate less than normal functioning
☐ Relieve acute symptoms, return to baseline functioning
☐ Maintain current status/prevent deterioration

Frequency of sessions: _____
Expected LOS: __Discuss_____
Modality CPT Code: _____

Clinician's Signature _____ **Date**_____

This form is to be used for routine outpatient psychotherapy only