



The Holman Group
Managed Behavioral Health Care Services

Assessment/Request for Treatment Follow-Up Authorization

(For initial MD visit only)

Patient: _____ Insured: _____

Insured's Social Security #: _____ Relationship: _____

Employer/Union: _____

Date of Birth: _____ Age: _____ Patient's Phone #: _____

Provider/Facility: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

MENTAL STATUS EXAM (PLEASE CHECK APPROPRIATE BOX FOR EACH CATEGORY):

- | | | | | | | |
|------------------|---------------------------------------|---|-------------------------------------|--|---|------------------------------------|
| Orientation: | <input type="checkbox"/> Intact | <input type="checkbox"/> Impaired: | <input type="checkbox"/> Date | <input type="checkbox"/> Place | <input type="checkbox"/> Time | <input type="checkbox"/> Situation |
| Appearance: | <input type="checkbox"/> Well-groomed | <input type="checkbox"/> Disheveled | <input type="checkbox"/> Bizarre | <input type="checkbox"/> Inappropriate | | |
| Motor Activity: | <input type="checkbox"/> Calm | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Agitated | <input type="checkbox"/> Tremors/Tics | <input type="checkbox"/> Muscle Spasms | |
| Speech: | <input type="checkbox"/> Normal | <input type="checkbox"/> Slowed | <input type="checkbox"/> Pressured | <input type="checkbox"/> Slurred | <input type="checkbox"/> Stuttering | |
| Thought Process: | <input type="checkbox"/> Intact | <input type="checkbox"/> Circumstantial | <input type="checkbox"/> Tangential | <input type="checkbox"/> Flight of Ideas | <input type="checkbox"/> Loose Associations | <input type="checkbox"/> Confused |
| Mood: | <input type="checkbox"/> Normal | <input type="checkbox"/> Depressed | <input type="checkbox"/> Anxious | <input type="checkbox"/> Euphoric | | |
| Affect: | <input type="checkbox"/> Appropriate | <input type="checkbox"/> Labile | <input type="checkbox"/> Expansive | <input type="checkbox"/> Constricted | <input type="checkbox"/> Blunted | |
| Hallucinations: | <input type="checkbox"/> None | <input type="checkbox"/> Auditory | <input type="checkbox"/> Visual | <input type="checkbox"/> Olfactory | <input type="checkbox"/> Command | |
| Delusions: | <input type="checkbox"/> None | <input type="checkbox"/> Persecutory | <input type="checkbox"/> Grandiose | | | |
| Memory: | <input type="checkbox"/> Intact | <input type="checkbox"/> Impaired: | <input type="checkbox"/> Immediate | <input type="checkbox"/> Recent | <input type="checkbox"/> Remote | |
| Judgement: | <input type="checkbox"/> Intact | <input type="checkbox"/> Impaired: | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | |

DSM IV Dx:

I . _____ II . _____ III . _____
IV. _____ V. Current _____ Past year _____

Medical History: _____

Mental Health/Treatment History: _____

Substance Abuse use and History: _____

Medication History: _____

Medications, dosage, frequency, start date: _____

Received informed consent for medication: Yes No N/A Any allergies?: Yes No

List all dates of service utilized during and beyond the current authorization period (specific dates): _____

Type of treatment requested: Medication Mgt.

90862 - Limited Follow-up 90805-Med. Mgt. w/Therapy Other: _____

Dates Requesting: From _____ To _____ Frequency _____ wk _____ mo _____ yr _____

Brief narrative of patient's current complaints and coping strategies: _____

Drug & Alcohol current use and history

None Use Dependence Inpatient Treatment _____ Outpatient Treatment _____ 12 Step _____

Substance(s)	Quantity	Frequency	Date of last use	Duration of use	Number of attempts at sobriety	Type CD treatment

Treatment Plan:

Current Symptom (i.e., sleep disturbance, poor concentration, decreased appetite, etc.)	Intervention (i.e., medication management, cognitive restructuring, guided imagery, reframing, etc.)	Target Date	Estimated Termination Date
1.	1.		
2.	2.		
3.	3.		
4.	4.		

Use of adjunctive therapies: outpatient therapy, self-help programs, etc. (e.g., Alcoholics Anonymous): _____

Recommended Referrals: _____

To request referrals under the patient's mental health benefits please call (800) 321-2843.

If applicable, I have coordinated care with other treating providers: **YES** **NO** **N/A**

I certify that the above is true and correct:

Provider's Signature: _____ Date: _____

Authorization is hereby given to Provider to release to The Holman Group any information which he/she deems necessary to evaluate for insurance purposes.

Signature of Patient, Parent or Guardian: _____ Date: _____

(Signature on file is not acceptable) If any information is omitted, this form will be returned to the Provider.

For The Holman Group Use Only:

Number of Sessions/Days: _____

Level: Individual ___ Conjoint ___ Group ___ Other ___

Dates: From _____ To _____ Initialed _____

The Holman Group Care Management Department recommends a referral to: _____

C.M./U.M.C. Notes: _____