INTEGRATED BEHAVIORAL HEALTH
REQUEST FOR CONTINUED MEDICATION MANAGEMENT

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 IV (Stressors): _____
Axis I (2):	_____	_____	_____
Axis II:	_____	_____	Axis V: Current GAF: _____
Axis III:	_____	_____	Highest GAF Past Year: _____

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

4. **REQUESTED SERVICES**

	Sessions to Date	**Requested Sessions**	**Frequency** ***(circle week or month)***	**Requested Cert Period (Dates) From**	**To**
Pharmacotherapy Mgmt. (90862)	_____	_____	(at_____/week/month)	_____	_____
Therapy w/meds mgmt * (90805/90807)	_____	_____	(at_____/week/month)	_____	_____

*NOTE: PLEASE ATTACH DETAILED RATIONALE FOR REQUESTING EXTENDED SERVICES INCLUDING SPECIFIC BEHAVIORAL GOALS AND STRATEGIES.

5. **PROGRESS**:

   a. Overview of Progress since last report (Please document any significant change in functioning):

   b. Rationale for medications changes and response:

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6. **MEDICATIONS** Insured SS#_____

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

7. If patient is on lithium, carbamazapine or valproic acid, please give the most recent blood level:

Medication: _____ Blood level: _____ Date: _____

Medication: _____ Blood level: _____ Date: _____

8. **MEDICATION TREATMENT GOALS** **MEDICATION FOR EACH GOAL**

1. GOAL:_____ _____

AS MEASURED BY: _____ _____

2. GOAL:_____ _____

AS MEASURED BY: _____ _____

3. GOAL:_____ _____

AS MEASURED BY: _____ _____

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

9. Other Service Providers:

a. Other providers be involved in treatment: License Type: ☐ M.D. ☐ Ph.D./Psy.D. ☐ MFT/LCSW

b. Please indicate Provider Name: _____
(Please Print)

c. Services to be provided: ☐ Medications ☐ Marital/Family Therapy ☐ Individual Therapy ☐ Evaluation/Assessment

☐ Group ☐ Other _____ Document date of last contact with this provider: _____

10. Termination Plan:

a. Anticipated duration of medication management: _____
b. Prognosis *(based on what indicators?)*: ☐ Good ☐ Fair ☐ Poor _____
_____

c. Compliance with medication: ❒ Good ❒ Fair ❒ Poor
Plans to address problems with compliance if it is not rated " Good":_____
_____

PROVIDER NAME *(please print)*: _____

I acknowledge that I am personally providing the treatment services requested herein (with the exception of those stated in item 9).

_____ _____
Physicians Signature **Date**

Return to: **IBH/** Care Management Service, P. O. Box 30018, Laguna Niguel, CA 92607-0018; Confidential FAX (714)556-5430