INTEGRATED BEHAVIORAL HEALTH (IBH)
INITIAL MENTAL HEALTH TREATMENT PLAN

RECEIVED BY IBH

(FOR OFFICE USE ONLY)

Patient Name: _____ DOB: _____ Sex: M F Insured SS#: _____

Insured Name: _____ Employer: _____ Report Date: _____

Practitioner Name: _____ License# / State: _____ License Type: _____ Tax ID #: _____

Practitioner Address: _____ City/State/Zip: _____ Phone #: _____

A. **HISTORY OF CURRENT EPISODE:** Date this treatment began: _____ Type and amount of treatment for this episode to date: _____

B. PRESENTING PROBLEMS (Patient's Stated Reason For Treatment): **PRESENTING SYMPTOMS** (Symptoms that justify Current Diagnoses):

C. BRIEF HISTORY (Relevant to Presenting Problems and Symptoms):

D. CURRENT DSM DIAGNOSES *(All 5 Axes MUST be completed with Code Number AND Description):*

	Code	Description
Axis I (1):		
Axis I (2):		
Axis II:		
Axis III:		
Axis IV (Stressor):		
Current GAF:	Highest GAF Past Year:	

E. PATIENT HISTORY

1. Is patient recently (< 30 days) discharged from a higher level of care? ☐ No ☐ Yes
   ☐ acute inpatient ☐ residential ☐ day treatment
2. Is the patient on psychiatric or chemical dependency disability? ☐ No ☐ Yes
3. Has the patient had a medical examination within the past 6 months? ☐ No ☐ Yes
4. Has there been a recent significant deterioration or loss of functioning? ☐ No ☐ Yes
   Explain:

F. REQUESTED SERVICES:

	Sessions Completed To Date	# Sessions Requesting	Frequency	Requested Cert Period (Dates)² From¹	To
Individual Therapy (90806/807)			(at____x/ ☐week ☐month)		
Group Therapy (90853)			(at____x/ ☐week ☐month)		
Family Therapy (90847)			(at____x/ ☐week ☐month)		
Medication Mgmt. (90862)			(at____x/ ☐week ☐month)		
Other: _____			(at____x/ ☐week ☐month)		

¹Pre-certification will begin from the date IBH receives this Treatment Plan. NO Retro-Authorization available. (May be faxed to: 714-556-5430)

²NOTE: Authorization for Psychotherapy visits are usually for about 3 months. For end of benefit year requests, please divide requested sessions between end of current year and beginning of next year.

NOTE: Please call (800) 395-1616 IBH Care Management if:

1) A medication evaluation referral is needed.
2) *****More than one visit per week is requested
3) *****Psychological Testing is requested
4) *****Biofeedback is requested
5) A higher level of care or a major change in treatment plan is indicated.
6) A referral to another IBH network provider is being requested.

***To request pre-authorization for these services, the provider MUST call for review with an IBH ClinicalCare Manager.**

IBH Initial Mental Health Treatment Plan

G: MEDICATIONS (ALL PROVIDERS to document) Patient: _____

CURRENT MEDICATIONS

Name	Dosage/Frequency	Name	Dosage/Frequency
1.		3.	
2.		4.	

List prescribing physician if you are not the prescriber: _____

If no medications are prescribed, have you discussed with patient the possibility of using medication? ☐ No, meds not indicated ☐ Yes, patient refuses

H: CURRENT RISK ASSESSMENT:

Harm to Self ☐ None ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent w/means *If risk exists: Patient is able to contract not to harm:* ☐ *Self* ☐ *Others*

Harm to others ☐ None ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent w/means Other Safety issue details: _____

Impulse control: ☐Sufficient ☐ Moderate ☐ Minimal ☐ Inconsistent ☐ Explosive _____

Current physical or sexual abuse or child/elder neglect? ☐ Yes ☐ No

If "Yes" patient is: ☐ Victim ☐ Perpetrator Legally reported? ☐ Yes ☐ No

Alcohol use: ☐ Not Significant ☐ Abuse ☐ Dependence *Specify quantity, frequency, and date of last use:*

Substance use: ☐ Not Significant ☐ Abuse ☐ Dependence _____

I. TREATMENT GOALS AND STRATEGIES ***(Specific, Observable, and Measurable)***

1) TREATMENT GOAL: _____

PROGRESS TO BE MEASURED BY: _____ TARGET DATE: _____

TREATMENT STRATEGIES / INTERVENTIONS: _____

2) TREATMENT GOAL: _____

PROGRESS TO BE MEASURED BY: _____ TARGET DATE: _____

TREATMENT STRATEGIES / INTERVENTIONS: _____

3) TREATMENT GOAL: _____

PROGRESS TO BE MEASURED BY: _____ TARGET DATE: _____

TREATMENT STRATEGIES / INTERVENTIONS: _____

(Please use separate sheet for additional goals and strategies for this patient)

Treatment Plan discussed with patient, guardian or other legal representative, or parent of a minor? ☐ Yes ☐ No

J. TREATMENT COORDINATION

a. Will other providers be involved in treatment? ☐ No ☐ Yes License Type: ☐ MD/DO ☐ PhD/PsyD ☐ LMFT/LCSW/LPC

b. Services to be provided by others: ☐ Medications ☐ Mar/Fam Therapy ☐ Individual Therapy ☐ Other: _____

c. Document date of your last contact to coordinate treatment with other provider(s): _____

d. Adjunctive/Community referrals utilizing (support groups, etc.): _____

e. Treatment coordinated with PCP? ☐ Yes ☐ No ☐ N/A

K. TERMINATION PLAN

a. Anticipated length of medically necessary treatment: ☐ 1 - 3 mos ☐ 3 - 6 mos ☐ > 6 mos Est. Date of Termination Session: _____ Est. # Sessions to Complete Treatment: _____

(if > 6 mos, document patient conditions that justify long term treatment that is medically/clinically necessary):

b. Prognosis: ☐ Good ☐ Fair ☐ Poor *Based on what indicators?* _____

L. PROVIDER NAME *I acknowledge that I am personally providing the treatment services requested herein, and that I am independently licensed:*

X_____ _____

Provider Signature Date License # Print Name

Return to: Integrated Behavioral Health
Care Management Services
P. O. Box 30018
Laguna Niguel, CA 92607-0018
Confidential FAX: (714) 556-5430