Print Form

Solano County Medi-Cal

Outpatient Treatment Progress Report

To request further authorizations, please fax or mail to:
Solano County Managed Care Program
275 Beck Ave. MS 5-235
Fairfield, CA 94533-0677
Phone: (800) 547-0495 FAX: (707) 425-4320

Please type or print clearly and complete this form in its entirety. For entries marked with an asterisk (*), use the Authorization for Service letter you received to obtain the necessary information.

Indicate if this in an emergency: ☐ Yes ☐ No If yes, call 1-800-547-0495. If no, please fax form to 1-707-425-4320

Client Information

Client Name* (First & Last) | Authorization Number* | Date Last Seen

Guardian/Parent Name | Client's Date of Birth* | Total # of Sessions You Have Client Seen

Client's Home Phone | Work Phone | Medi-Cal Number | Other Insurance (e.g., Medicare, HMO)

Client's Primary Care Physician | Initial Telephone Contact Date | Evaluation Date

Provider Name | Provider Phone | Provider Fax | Provider Email Address

Current Risk Factors

- Suicidality: ☐ None ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent with means
- Homicidality: ☐ None ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent with means
- If risk exists, client is able to contract not to harm: ☐ Self ☐ Others
- Impulse Control: ☐ Sufficient ☐ Moderate ☐ Minimal ☐ Inconsistent ☐ Explosive
- Medical Risks: ☐ Yes ☐ No If "Yes," explain: _____
- Substance Abuse: ☐ None ☐ Abuse ☐ Dependence ☐ Unstable remission
- Specifics: _____
- **Current** physical or sexual abuse, or child/elder neglect: ☐ Yes ☐ No
- If yes, client is: ☐ Victim ☐ Perpetrator ☐ Both ☐ Neither, but abuse exists in family
- Abuse/neglect involves a child/elder: ☐ Yes ☐ No Legally reported: ☐ Yes ☐ No
- Specifics: _____

Current Medication

☐ None ☐ Psychiatric ☐ Physical ☐ No Information

Medication Name	Dosage	Frequency	Compliance	Prescribing Physician

☐ Allergies If yes, specify: _____

Efforts of Coordination of Care with Primary Care Physician (PCP)

Please list efforts to contact PCP and information shared. Communication between the Behavioral Health Provider and the PCP should include, at a minimum, diagnosis, expected duration of treatment and any psychological/pharmacologic treatment recommendations. _____

Symptoms & Problems

Severity Rating: **1 = Mild** **2 = Moderate** **3 = Severe**

Duration Rating: **1= Less than 1 month** **2 = 1 to 6 months** **3 = 7 to 11 months** **4 = 1 year or longer**

	Severity	Duration		Severity	Duration		Severity	Duration
Anxiety			Poor Interpersonal Skills			Sexual Dysfunction		
Appetite Disturbance			Poor Judgment			Sleep Disturbance		
Bizarre Behavior			Impaired Memory			Somatization		
Conduct Problems			Obsessive-Compulsive			Other:		
Depression			Panic Attacks					
Gender Issues			Paranoid Ideation			Other:		
Bizarre Ideation			Phobia					
Indep. Living Problems			Poor Self-Care Skills					

Provide brief description of impairments/presenting problems in activities of daily living, social, occupational/academic or other important area(s) of life functioning:

Current Diagnosis (check only one Primary Diagnosis)

Axis I ☐ Pri ☐ Sec DSM Code: _____ Name: _____

Axis II ☐ Pri ☐ Sec DSM Code: _____ Name: _____

Axis III General Medical Condition ICD Code: _____ Name: _____

Axis IV Psychosocial and Environmental Problems ***Check all that apply*:**

- ☐ A. primary support group
- ☐ B. social environment
- ☐ C. education
- ☐ D. occupational
- ☐ E. housing
- ☐ F. economics
- ☐ G. access to health care
- ☐ H. interaction with legal system
- ☐ I. other psychosocial/environmental
- ☐ J. inadequate information

Axis V Current **GAF**: _____ Highest **GAF** (in past 12 months): _____

Individual &/or Family Strengths Relevant to Achieving Treatment Goals

Transition/Termination Plan

Please document progress client has made toward achieving treatment goals relevant to successful termination. Document community resources that have been discussed with the client, and which community resources the client has connected with that will aid them, following successful termination of services.

Treatment Plan

Treatment goals must be specific observable and/or specific quantifiable. You should be able to tell when the client has reached their goal, e.g. "as evidenced by…"

Goal #1: _____

_____

Proposed Method for Achieving Goal/Interventions: _____

_____

Proposed Duration: _____

_____

Progress Since Last Report: ☐ New Goal ☐ Much Worse ☐ Slight Improvement ☐ Somewhat Worse ☐ Significant Improvement ☐ No Change ☐ Resolved

Treatment Plan - Continued

Goal #2: _____

_____

Proposed Method for Achieving Goal/Interventions: _____

_____

Proposed Duration: _____

_____

Progress Since Last Report: ☐ New Goal ☐ Much Worse ☐ Slight Improvement ☐ Somewhat Worse ☐ Significant Improvement ☐ No Change ☐ Resolved

Re-Authorization of Services Request

Service Type		**Frequency**		**Totals**	
Individual Therapy:	☐ Monthly	☐ Every other week	☐ Weekly	**Total** Sessions Requested	_____
Group Therapy:	☐ Monthly	☐ Every other week	☐ Weekly	**Total** Sessions Requested	_____
Family Therapy:	☐ Monthly	☐ Every other week	☐ Weekly	**Total** Sessions Requested	_____

Signatures

The signatures below indicate that the client and provider have agreed to this plan and that the client was offered a copy of this plan.

Check one: ☐ Client *accepted* a copy of this plan ☐ Client *declined* a copy of this plan

_____ Client Signature Date

_____ Provider Signature and Licensure/Degree Date

_____ Parent/Caregiver/Guardian Date

_____ Print Provider Name and Licensure/Degree

If no client signature, document why and describe how the client/caregiver was involved in the development of this plan and how they have indicated agreement with the plan: _____

_____