Solano County Medi-Cal

Psychiatric Medication Evaluation/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 Services 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 Primary Care Physician	Initial Telephone Contact Date	Evaluation Date

Provider Name	+Provider Phone	+Provider Fax	+Provider Email Address

+ = complete only if changes

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: ____________________

Risk History

Explain any significant history of suicidal, homicidal, impulse control, medical or substance abuse behavior.

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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					

Medical History

For **Initial Evaluation**, list significant past and present medical conditions. For **Progress Report**, list changes in medical condition since last update.

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Medication History

For **Initial Evaluation**, list significant past and present medications not prescribed by yourself. For **Progress Report**, list discontinued trials since last report. ☐ None ☐ No Information

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Current Medication

☐ None (If none, explain in Plan) ☐ Psychiatric ☐ Physical ☐ No Information

Medication Name	Dosage	Frequency	Target Dose	Compliance	Prescribing Physician

☐ Allergies If yes, specify: ____

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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 ☐ E. housing ☐ I. other psychosocial/environmental

☐ B. social environment ☐ F. economics ☐ J. inadequate information

☐ C. education ☐ G. access to health care

☐ D. occupational ☐ H. interaction with legal system

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

Plan & Recommendations

Describe specific monitoring parameters to be followed, anticipated schedule of drug increase or decrease, change or discontinuation.

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Medication Monitoring Request: ☐ 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

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Client Signature Date

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Provider Signature and Licensure/Degree Date