empower
HEALTHCARE SOLUTIONS

Outpatient Information for Residential Requests

Provider Name: _____Contact number: _____
Beneficiary ID: _____
Last name: _____ First name: _____
Date form completed: _____
Psychiatric diagnosis (include all) during outpatient during OP treatment:
_____
_____
_____
_____
Problems/Behaviors addressed in treatment plan:
_____
_____
_____
_____
_____
What progress/improvements observed (explain)?
_____
_____
_____
_____
_____
Client/family strength (include natural supports):
_____
_____
_____
_____
List all agencies contacts that are currently involved in the client's care (please include phone number): _____
_____
_____
_____
Date client last attended individual therapy session: _____
Are sessions routinely missed? _____
Date client and family attended last family therapy session: _____
Is family active and involved? _____
Date client attended last medication management session: _____
Are meds being refused? _____
How often is client seen for medication management? _____

Was Crisis Interventions provided within the last 6 months to client or family?

_____

Was there a positive outcome? (Describe)

_____

_____

_____

_____

Frequency of:

a.) Individual therapy from LMHP: _____ Total # of sessions within last 90 days_____

b.) Family therapy sessions from LMHP: _____ Total # of sessions within last 90 days

_____

Other OP services received (frequency &type i.e. case management, rehab day, community supports): _____

_____

_____

_____

Describe the current symptoms client is displaying in the school, community and at home that cannot be managed safely in an outpatient treatment setting: (specify if behavior only occurs in a specific setting):_____

_____

_____

_____

List type(s) and date(s) of serious physically aggressive or destructive acts committed by the client in the last 30 days: _____

_____

_____

_____

Legal charges? _____ (Describe, (reason/type)?

_____

_____

_____

List the dates and length of stay of acute hospitalizations in last 12 months:

_____

_____

_____

_____

What will occur in the residential setting to support client return to family/community?

_____
_____
_____
_____

OP Clinic name: _____
City/Location: _____
Name/Signature of Therapist:_____ Date: _____

(**Additional documents may be submitted to support the request**)