

# Combined MCO Outpatient Review Form/Massachusetts

Please Fax to NHP/FCHP/BMC HealthNet/Beacon: 1.781.994.7634; to Network Health: 1.888.977.0776

<b>MEMBER INFORMATION</b> <i>(Verify eligibility before rendering services)</i>
Member Name _____
Member ID# _____ D.O.B. _____

<b>PROVIDER INFORMATION</b>
Agency Name _____
Provider ID _____
Clinician Name _____
Phone # _____ ext. _____
Fax# _____

<b>TREATMENT STATUS</b>					
<i>(Please rate the patient's response to treatment since last review or since start of treatment if this is first report)</i>					
	Much Worse	Slightly Worse	No Changes	Slight Imprvmt	Major Imprvmt
Behavioral Symptoms that are focus of treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to perform work/school/household tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>CURRENT PSYCHOTROPIC MEDICATIONS</b>
Are Psychotropic meds being prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, prescribed by: <input type="checkbox"/> MD <input type="checkbox"/> RN,CS/NP <input type="checkbox"/> PCP
Prescriber: _____
List Meds: _____

<b>DSM-IV DIAGNOSIS</b>
Axis I _____
Axis II _____
Axis III _____
Axis IV _____
GAF (0-100) _____ HGAF _____
Have you communicated with member's PCP in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
With the prescriber? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

<b>CURRENT RISK INDICATORS</b>
<i>(Check all that apply)</i>
<input type="checkbox"/> Current substance abuse <input type="checkbox"/> Fire setting
<input type="checkbox"/> Caring for ill family member <input type="checkbox"/> Impulsive behavior
<input type="checkbox"/> Self-mutilation/cutting <input type="checkbox"/> Assaultive behavior
<input type="checkbox"/> Current family violence (abuse, domestic)
<input type="checkbox"/> Sexually offending behavior <input type="checkbox"/> Psychotic Symptoms
<input type="checkbox"/> Coping with significant loss (job, relationship, financial)
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Prior psychiatric inpatient admission (date: _____)
<b>Site of treatment:</b>
<input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Other

<b>RISK ASSESSMENT</b> <i>(Check all that apply):</i>
<b>Suicidal Tendency:</b>
<input type="checkbox"/> not present <input type="checkbox"/> ideation <input type="checkbox"/> plan
<input type="checkbox"/> means <input type="checkbox"/> prior attempt (date _____)
<b>Homicidal Tendency:</b>
<input type="checkbox"/> not present <input type="checkbox"/> ideation <input type="checkbox"/> plan
<input type="checkbox"/> means <input type="checkbox"/> prior attempt (date _____)
<b>Rate member's level of psychological distress:</b>
<input type="checkbox"/> 1 (minimal) <input type="checkbox"/> 2 (mild) <input type="checkbox"/> 3 (moderate)
<input type="checkbox"/> 4 (marked) <input type="checkbox"/> 5 (severe)
<b>Current Risk of Psychiatric Hospitalization:</b>
<input type="checkbox"/> 1 (low) <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 (high)
<i>*If 3 or higher please explain: _____</i>
Has the member been in a higher level of care in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No

**STATUS OF THREE MOST SIGNIFICANT TARGETED GOALS SINCE TREATMENT INITIATION USING THE FOLLOWING SCALE:**

N = New Goal      1 = Much worse      2 = Somewhat worse      3 = No change  
 4 = Slight improvement      5 = Major improvement      R = Resolved

Goal	Modality <i>(Individual, group, CBT, etc.)</i>	Progress <i>(Since treatment initiation – indicate rating #)</i>
1.		
2.		
3.		

**Agency Involvement** *(Check all that apply)*

DMH       DCF       DYS       Court       EAP       Other

Foster Care Placement       AA       Dev. Disability

**Family/Social Involvement** *(Check all that apply)*

Family       Spouse/Partner       Friends       Religious group

Community Resources

**REQUEST FOR SESSIONS**

I request \_\_\_\_\_ sessions over the next \_\_\_\_\_ months. Starting on \_\_\_\_\_

Member in treatment with provider since \_\_\_\_\_

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Was a standard instrument used to evaluate treatment progress?**  Yes  No

**If so, which instrument?** \_\_\_\_\_