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Child and Adolescent Psychiatry Department - Woodland Hills

**\*\*FORM IS DUE within ONE business day of session\*\***

**Submit via encrypted email to:** [**WH-OutsideMedicalCase-Management@kp.org**](mailto:WH-OutsideMedicalCase-Management@kp.org)

**\*\*Incomplete forms will be returned \*\* No retroactive authorization will be issued\*\***

**INITIAL DIAGNOSTIC INTERVIEW**  Date of Service:

LENGTH OF SESSION: 50 minutes -- CPT: 90791

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** |  | Kaiser MRN: |  |
| Date of Birth: |  |  |  |

INDIVIDUALS PRESENT:

OTHER SOURCES OF INFORMATION:

Living with:

**PRESENTING CONCERNS (include reasons for seeking tx, general functioning at school and home)**

**BEHAVIORAL HEALTH HISTORY:**

**PRE-NATAL OR EARLY LIFE TRAUMA:**

**DRUG OR ALCOHOL USE (TEEN OR FAMILY):**

**DIAGNOSTIC IMPRESSION:**

**ASSESSMENT and TREATMENT PLAN:**

Provider Name and License:

Provider Email and Phone:

Date: