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Outpatient Substance Abuse Rehabilitation Treatment Plan Form

Mailing Address: Behavioral Health Department, 48 Monroe Turnpike Trumbull, CT 06611 **Phone:** 1-800-201-6991 **Fax:** 1-800-760-4041

IF YOU HAVE ALREADY SUBMITTED A TREATMENT PLAN FORM, PLEASE COMPLETE PAGE 2 ONLY.

Section I. Member and Provider Information

Treating provider: _____ Provider ID #: _____

Provider phone number: _____ Provider fax number: _____

Member ID #: _____ Reference #: _____

Member initials: _____ Date of evaluation: ____/____/____ Member age: _____

Date of first session: ____/____/____ Number of sessions since start of treatment: _____

Has Member given approval to contact his/her PCP? ❑ Yes ❑ No Have you contacted the Member's PCP? ❑ Yes ❑ No

Section II. Diagnosis DSM-IV Numbers Description

Substance Abuse/Psychiatric:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V Past year: _____ Current: _____

Section III. Current Substance Abuse

SUBSTANCE	AGE OF FIRST USE	FREQUENCY OF ABUSE	AMOUNT USED	DATE LAST USED	ADDITIONAL INFORMATION
Alcohol					
Cannibis					
Cocaine					
Benzodiazepine					
Opioid					
Other					

Check applicable: ❑ Job jeopardy ❑ Legal issues ❑ School difficulty

Section IV. Treatment History

Substance abuse treatment(s): ❑ None ❑ Inpatient detox ❑ Inpatient rehab ❑ Outpatient rehab ❑ Other _____

Duration of SA treatment: _____ _____ _____ _____ _____

Time since last Tx: ❑ 0-1 year ❑ 1-2 years ❑ 2-4 years ❑ 4+ years

Longest period of abstinence: ❑ 0-1 year ❑ 1-2 years ❑ 2-4 years ❑ 4+ years

Mental health treatment: ❑ Inpatient/partial ❑ IOP ❑ Outpatient Medications (Current/Past) _____

Duration of MH treatment: _____ _____ _____ Dosage/frequency _____

Section V. Current Support System

❑ Family ❑ Friends ❑ Sponsor/Self-help ❑ Employer/EAP ❑ Religious ❑ Other _____

Section VI. Treatment Plan

Is patient motivated to engage in treatment? ❑ Yes ❑ No Court-mandated treatment? ❑ Yes ❑ No

TREATMENT	TREATMENT START DATE	EXPECTED DISCHARGE DATE	FREQUENCY	DURATION	TOTAL NUMBER OF VISITS REQUIRED
Outpatient Rehabilitation					
Family Rehabilitation					
Medication Management: ❑ Yes ❑ No					
Other:_____					

Goals/Updates:

_____

_____

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Member ID #: _____ Reference #: _____

Member initials: _____ Date of evaluation: ____/____/____ Member age: _____

Date of first session: ____/____/____ Number of sessions since start of treatment: _____

Has Member given approval to contact his/her PCP? ❑ Yes ❑ No Have you contacted the Member's PCP? ❑ Yes ❑ No

Section VII. Response to Treatment

1. Has the patient attended a treatment program on a regular basis? ❑ Yes ❑ No
2. Has the patient attended a 12-step or other program on a regular basis? ❑ Yes ❑ No

   If no to either of the above, why? _____

   _____

   If so, do they have a home group and sponsor? ❑ Yes ❑ No
3. Is there family involvement? ❑ Yes ❑ No

   If so, who and to what extent? _____

   If no, why? _____
4. Has the patient relapsed? ❑ Yes ❑ No

   If so, when? _____ How has the treatment plan changed to address the relapse? _____

   _____
5. How is the potential for relapse addressed in the treatment plan? _____

   _____
6. Is the patient on psychiatric medications? ❑ Yes ❑ No

   If so, please describe current medications and response to treatment. _____

   _____

   Who is prescribing medications? ❑ PCP ❑ Psychiatrist: _____
   Name
7. List other changes in: treatment plan/patient's response/diagnosis. _____

   _____
8. What is the discharge plan? _____

   _____
9. What is the estimated length of treatment? _____
10. How many additional visits are being requested? _____

Provider signature: _____ Date: _____

For Insurer Use Only: ____ additional sessions have been certified from ___ /___ /___ to ___ /___ /___ by the Behavioral Health Department. A total of _____ sessions (including prior sessions) have been authorized by. Note: All certifications are based upon Member eligibility and benefit availability at the time services are rendered.