



Preferred Care Outpatient Chemical Dependency Treatment Summary

Date: _____

Member Name: _____ ID#: _____ Precert #: _____
Program: _____ Admit Date: _____ Anticipated Discharge: _____
Employment: [] Not employed [] On disability [] Part/full time employment

ADMITTING DIAGNOSIS:

Axis I: _____ Axis IV: _____
Axis II: _____ Axis V: _____
Axis III: _____

Has the diagnosis changed since the last summary? [] No [] Yes (specify) _____

MENTAL HEALTH TREATMENT:

[] No MH needs
[] MH Tx from this program
[] MH Tx from outside program (specify provider): _____

MEDICATIONS:

RESULT OF LAST DRUG SCREEN: Date: _____ [] Negative [] Positive for _____

ATTENDANCE: [] Irregular attendance [] Attends regularly
PARTICIPATION IN TX: [] Minimal interaction [] Actively participates
[] Quiet, but pays attention [] Seen as positive role model
12 STEP MEETING: [] Does not attend [] Sporadic attendance [] Regular attendance
CURRENT TX PHASE: [] Phase I [] Phase II [] Phase III
[] Other (specify) _____

IS THE MEMBER'S FAMILY / SIGNIFICANT OTHER INVOLVED IN TREATMENT? [] Yes [] No [] Refused

RATIONALE / JUSTIFICATION FOR THE NEED FOR CONTINUED AUTHORIZATION OF SERVICES: Please include current functional impairments, understanding of disease concept, and what the member specifically needs to obtain to complete this phase of treatment: _____

REASON FOR REQUEST:

[] Request additional visits (specify): _____ [] Individual # _____ [] Group # _____
[] Transfer to higher/different level of care [] IOP [] Inpatient Rehab [] Inpatient Detox

Counselor: _____ Phone #: _____

Please fax to the Behavioral Health Dept. at 585-454-1446

Please call the Behavioral Health Dept. with any questions at 585-258-8077. Thank you.