**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.13(2), Wis. Admin. Code

F-11103 (10/2008)

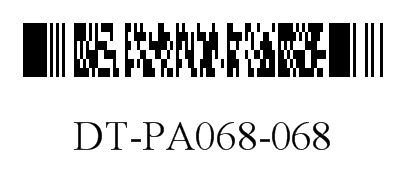
**FORWARDHEALTH**

**OUTPATIENT MENTAL HEALTH ASSESSMENT AND TREATMENT / RECOVERY PLAN**

The use of this form is voluntary and optional and may be used in place of the consumer’s assessment and treatment/recovery plan.

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| **SECTION I — INITIAL ASSESSMENT / REASSESSMENT**  Date of initial assessment / reassessment (MM/DD/CCYY) Date of initial assessment / reassessment (MM/DD/CCYY) |
| 1. Presenting Problem   Presenting Problem |
| 1. Diagnosis (Use current *Diagnostic and Statistical Manual of Mental Disorders* [DSM] / *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* [DC: 0-3] code and description.)   Axis I Axis I |
| Axis II Axis II |
| Axis III Axis III |
| Axis IV (List psychosocial / environment problems.) Axis IV (List psychosocial / environment problems.) |
| Axis V (Current Global Assessment of Functioning [GAF].) Axis V (Current Global Assessment of Functioning [GAF].) |
| 1. Symptoms (List consumer’s symptoms in support of given DSM / DC:0-3 diagnoses.) Symptoms (List consumer’s symptoms in support of given DSM / DC:0-3 diagnoses.)   Severity of Symptoms  Mild  Moderate  Severe |
| 1. Strength-Based Assessment (Include current and historical biopsychosocial data and how these factors will affect treatment. Also include mental status, developmental and intellectual functioning, school / vocational, cultural, social, spiritual, medical, past and current traumas, substance use / dependence and outcome of treatment, and past mental health treatments and outcomes.)   Strength-Based Assessment |
| 5. Describe the consumer’s unique perspective and own words about how he or she views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values, and lifestyle of the consumer, areas of functional impairment, family and community support, and needs.  Describe the consumer’s unique perspective and own words |
| 1. What do you anticipate as barriers / strengths toward progress and independent functioning?   What do you anticipate as barriers / strengths toward progress and independent functioning? |

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| **SECTION I — INITIAL ASSESSMENT / REASSESSMENT (Continued)** | | | |
| 7. Has there been a consultation to clarify diagnosis / treatment?  Yes  No  If so, by whom?  Psychiatrist  Ph.D. Psychologist  Master’s-Level Psychotherapist  Other (Specify) Specify  Advanced Practice Nurse Prescriber-Psych / Mental Health Specialty  Substance Abuse Counselor  Date of latest consultation (MM/DD/CCYY) Date of latest consultation (MM/DD/CCYY)  Provide results of consultation or attach report, if available. Provide results of consultation or attach report, if available. | | | |
| **SECTION II — SUBSEQUENT ASSESSMENTS**  Not required when Initial Assessment section is completed. This section must be completed for subsequent reviews. | | | |
| 8. Indicate any changes in Elements 1-7, including the current GAF, change in diagnoses (five axes), and symptoms in support of new diagnosis, including mental status. Indicate any changes in Elements 1-7, including the current GAF, change in diagnoses (five axes), and symptoms in support of new diagnosis, including mental status. | | | |
| 9. Describe current symptoms / problems.  Anxiousness  Homicidal  Oppositional  Somatic Complaints  Appetite Disruption  Hopelessness  Panic Attacks  Substance Use  Decreased Energy  Hyperactivity  Paranoia  Suicidal  Delusions  Impaired Concentration  Phobias  Tangential  Depressed Mood  Impaired Memory  Police Contact  Tearful  Disruption of Thoughts  Impulsiveness  Poor Judgment  Violence  Dissociation  Irritability  School / Home / Community Issues  Worthlessness  Elevated Mood  Manic  Self-Injury  Guilt  Obsessions / Compulsions  Sexual Issues  Hallucinations  Occupational Problems  Sleeplessness  Other Other | | | |
| **SECTION III — TREATMENT / RECOVERY PLAN**  **Based on strength-based assessments.** | | | |
| 10. Treatment plan, as agreed upon with consumer.  Short term (Three months) Short term  Long term (Within the next year) Long term (Within the next year)  Specify objectives utilized to meet the goals. Specify objectives utilized to meet the goals.  Indicate modality (Individual [I], group [G], family [F], other [O]) after each objective. Indicate modality (Individual [I], group [G], family [F], other [O]) after each objective. | | | |
|  | What are the therapist / consumer agreed-upon signs of improved functioning?  As reported by As reported by | Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver’s report. | Changes in Goals / Objectives |
| 1 | What are the therapist / consumer agreed-upon signs of improved functioning? | Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver’s report. | Changes in Goals / Objectives |

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| **SECTION III — TREATMENT / RECOVERY PLAN (Continued)** | | | | |
|  | What are the therapist / consumer agreed-upon signs of improved functioning?  As reported by As reported by | Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver’s report. | | Identify changes in goals / objectives. |
| 2 | What are the therapist / consumer agreed-upon signs of improved functioning? | Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver’s report. | | Identify changes in goals / objectives. |
| 3 | What are the therapist / consumer agreed-upon signs of improved functioning? | Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver’s report. | | Identify changes in goals / objectives. |
| 1. How are consumer’s strengths being utilized? How are consumer’s strengths being utilized?   If little or no progress is reported, discuss why you believe further treatment is needed and how you plan to address the need for continued treatment. What strategies will you, as the therapist, use to assist the consumer in meeting his / her goals? If progress is reported, give rationale for continued services. Discuss why you believe further treatment is needed and how you plan to address the need for continued treatment.     1. Is consumer taking any psychoactive medication? Yes No   Date of last medication check (MM/DD/CCYY) MM/DD/CCYY    List psychoactive medications and dosages.  Medication and Dosages Medication and Dosages Target Symptoms Target Symptoms  Medication and Dosages Medication and Dosages Target Symptoms Target Symptoms  Medication and Dosages Medication and Dosages Target Symptoms Target Symptoms  Is informed consent current for all medications?  Yes  No | | | | |
| **SECTION IV — SIGNATURES** | | | | |
| 1. **SIGNATURE** — Rendering Provider   SIGNATURE — Rendering Provider | | | 1. Date Signed   Date Signed | |
| 1. **SIGNATURE** —Consumer / Legal Guardian\*   SIGNATURE — Consumer / Legal Guardian (\*read footnote) | | | 1. Date Signed   Date Signed | |

\*The outpatient psychotherapy clinic certification standards requiring the consumer to approve and sign the treatment plan and agree with the clinician on a course of treatment, Wis. Admin. Code § DHS 36.16(3), will be met if this form is signed by the consumer/legal guardian for children.