INTERFACE EAP – CLINICAL FEEDBACK FORM

VOICE: 800-324-4327 or 713-781-3364 SECURE CLINICAL FAX: 800-304-4838 or 713-781-4954

This form is used to provide Interface EAP with clinical information and to request authorization.

Patient's First Name: ______________________ **Case Number:** ______________

Provider: ______________________ **Date Form Submitted:** ______________

I. Date(s) of sessions covered in this report: ______________________

II. Diagnoses

Axis I: ______________________

Axis II: ______________________

Axis III: ______________________

Axis IV: Stressors: ______________________

Axis V: Current GAF: __________ Highest GAF past year __________

III. Current Symptoms And Severity: ☐ Symptoms in remission due to medication

IV. Relevant History: ☐ No additional data since last clinical update

V. Current Medications And Dosages: ☐ No current psychotropic medications

VI. Patient's Current Level Of Risk (*include data on history and any plan*):

A. Suicide:
- [1] Probability: ☐ None ☐ Low ☐ Moderate ☐ High
- [2] Plan: ☐ None Specific Plan: ______________________
- [3] Intent: ☐ None Level of Intent: ______________________

B. Significant Violence Toward Others:
- [1] Probability: ☐ None ☐ Low ☐ Moderate ☐ High
- [2] Plan: ☐ None Specific Plan ______________________

VII. Proposed Treatment Plan (*D & E must be completed for long-term cases*):

A. Estimated length of treatment: ______________ ☐ Chronic condition -- indefinite treatment

B. Goals to be met before termination of treatment: ______________________

____

____

C. How are goals to be measured? ______________________

D. Progress since start of treatment? Completed ________ % of goals as evidenced by: ______________

____

____

E. Anticipated step-down date: ______________ Step-down frequency? ______________

F. Patient's response to treatment ☐ Poor ☐ Marginal ☐ Fair ☐ Good ☐ Excellent

VIII. Action Requested (*must be completed for authorization)*:

☐ Request remaining _____ EAP sessions & Close Case (*limited number; free to pt; not available in all cases*)

OR

☐ Long Term Issue: Request use of Insurance Benefits (*uninterrupted care for duration of treatment*)

1. CPT Code: __________ Frequency: __________ Number: ______________
2. CPT Code: __________ Frequency: __________ Number: ______________

☐ Referral to: ______________________ For: ______________________

☐ Close case - No further treatment necessary

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Modified On 7/8/2005 8:02 AM