

San Bernardino County
Department of Behavioral Health
ANNUAL PSYCHIATRIC ASSESSMENT REVIEW FORM

Authorization will be based on Medical Necessity (impairment in functioning) per DSM 4 Diagnosis.

Provider Name: _____

Provider Office Address: _____

Client Name: _____ **DOB:** _____ **SSN:** _____

Sex: Male Female **Age:** _____ **Allergies:** _____

Living Arrangement: Alone Bio Family Foster Family Group Home SNF B&C

MINOR'S: Ht: _____ Wt: _____ (mandatory for minors)

Minor is under the Jurisdiction of: DFS Court Probation Bio Family Other: _____

Mental Health Status Examination

Affect:	<input type="checkbox"/> Blunted/Flat	<input type="checkbox"/> Labile/Restricted	<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Appropriate
Mood:	<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious
<input type="checkbox"/> Angry	<input type="checkbox"/> Fearful	<input type="checkbox"/> Irritable	<input type="checkbox"/> Other: _____	
Behavior:	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Confused	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Secluded
<input type="checkbox"/> Uncooperative	<input type="checkbox"/> Demanding	<input type="checkbox"/> Guarded	<input type="checkbox"/> Suspicious	<input type="checkbox"/> Hostile
<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Psychomotor Retardation	<input type="checkbox"/> Cooperative		
Speech:	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Rapid	<input type="checkbox"/> Pressured	<input type="checkbox"/> Monotonous/Slow
Thought Process:	<input type="checkbox"/> Logical	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Tangential	<input type="checkbox"/> Flight of Ideas
Insight: <input type="checkbox"/> Good	<input type="checkbox"/> Poor	Judgment:	<input type="checkbox"/> Good	<input type="checkbox"/> Poor
Hallucinations:	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual	<input type="checkbox"/> Other: _____	

Diagnosis DSM - IV

Current Diagnosis:

Axis I _____ Axis II _____ Axis III _____

Axis IV _____ Axis V _____

If change in Diagnosis, address the following:

Date of change: _____ Behavioral changes to support change in diagnosis: _____

MANAGEMENT

Dysfunction rating: None Mild Moderate Severe

Describe how symptoms impair functioning: (Documentation must meet medical necessity).

CLIENT PLAN

How has your treatment benefited the client? Be behaviorally specific and address the problems and treatment goals on the Client Plan.

What plans/techniques/interventions will you use to address these problems?

(MD's, please address all current medications, dosages, and frequency)

List the treatment goals:

Goal #1: _____

Behavioral Specific Objectives: (observable, measurable, quantifiable, and time limited)

Goal #2: _____

Behavioral Specific Objectives: (observable, measurable, quantifiable, and time limited)

Modalities Requested: (Check) Number of sessions for 6 month period of time: _____

Individual Psychotherapy _____ Medication Support _____

Proposed Termination Date (Proposed end date for entire course of treatment): _____

Proposed Therapeutic Interventions: _____

Client Signature

QM005

Date

Quality Management

Provider Signature

Date

Page 1 of 1