



HEALTH SERVICE REVIEW, INC.
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Outpatient Mental Health Report

Please return this form to the fax number above.

THIS REPORT IS CONFIDENTIAL

Date: _____
 Provider Name &
 Credentials: _____
 Provider Address &
 Phone: _____

Provider Fax: _____

Patient Name: _____

Insured: _____

Insured SS#: _____

Diagnosis: (All five axes with codes and descriptions)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Date of initial office visit: _____

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A. Describe the patient's present reasons for treatment, severity of symptoms, functional impairment and pertinent history:

B. Progress toward goals and new problems/complications (follow-up report):

C. Treatment plan including focus and goals:

D. Psychotropic medications with dosage:

E. Number of additional sessions requested: _____

F. How frequently do you plan to see this patient: _____