PENN
BEHAVIORAL HEALTH
CORPORATE SERVICES

OUTPATIENT CONCURRENT REVIEW FORM

Patient Name- Last: _____ First: _____ MI: ____ DOB __ / __ / ____

Insurance: _____ Policy # _____

Provider: _____ Phone Nbr: (____) ____ - _____

1. **Symptom List** (Check all that apply)

a. **Psychosis** | Hallucinations | Delusions | Loose Associations | Dissociation | Inappropriate Affect

b. **Mood** ☐ Depressed Mood ☐ Hypomania ☐ Mania ☐ Sleep + or - ☐ Concentration
☐ Weight Loss/Gain ☐ Loss of motivation / pleasure ☐ Worthlessness / Guilt

c. **Anxiety** ☐ Panic Attacks ☐ Chronic Worrying ☐ Obsessive Thoughts ☐ Compulsive Behaviors
☐ Hyper Vigilance ☐ Phobia

d. **Somatic** ☐ G.I. ☐ Pain ☐ Conversion / Pseudonuerologic

e. **Developmental Disorders** ☐ Autism ☐ Aspergers ☐ Mental Retardation ☐ Other Learning Problems

f. **Disruptive Behavior** | Attentional | Impulsivity | Hyperactivity | Opposition / Conduct | Aggressive

g. **Cognitive** ☐ Dementia ☐ Delirium ☐ Distractable

h. **Substance** ☐ Abuse ☐ Dependence (Specify Type) _____
Court or other administrative involvement ☐ Yes ☐ No

i. **Learning/School/Work problems** _____

j. **Other Symptoms** (Specify) _____

k. **Suicidal Ideation** ☐ Yes ☐ No **Suicidal Attempt** ☐ **Yes** ☐ **No**

l. **Other self harm** | Yes | No **Homicidal Ideation** ☐ **Yes** ☐ **No**

2. **Treatment Type** (Check all that apply) ☐ Individual ☐ Family ☐ Group

3. **Treatment Modality** (Check all that apply)
☐ Cognitive Behavioral ☐ Interpersonal (including family systems therapy) ☐ Psychodynamic
Chemical Dependency | Support / Educational Psychoanalyis
Other (specify) _____

4. **Treatment Goal** (Check all that apply)
☐ Behavior/Cognitive change ☐ Mood/affect change ☐ Supportive treatment (maintain current functioning)
☐ Environmental change (including relationship change) ☐ Insight into problems
☐ Other (Specify) _____

5. **Please note any chronic medical problems** _____
_____
_____

6. **Is treatment being coordinated with a PCP?** ☐ Yes ☐ No

7. **Diagnosis** Axis I a. _____ b. _____ c. _____
Axis II _____ Axis III _____ Axis IV _____
GAF-Current _____ At beginning of treatment _____

8. **Current Meds**

	Type	Dose		Type	Dose
1.			3.		
2.			4.		

9. **Has this member been referred for medication management?**
☐ Yes ☐ No- not necessary ☐ No- member refuses ☐ No- cannot get appointment(call PBH for assistance)

Number of sessions requested for the current benefit year. ____

Have you notified PCP? ☐ Yes ☐ No ☐ No - Member Refused

Please return this form, completed accurately and legibly to:
OR
Fax to: 215-746-7454

Penn Behavioral Health
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