PLEASE FAX TO 812-378-7054

Southeastern Indiana Health Organization
Continued Outpatient Psychiatric Treatment Plan Update
Contact Name:_____ Phone:_____

Patient Name	**Patient's Birth Date**	**Date**
Patient ID #	**Therapist**	**Doctor**
Precert #	**Employer:**	**Date of 5th visit:**

Complete the following questions in regards to the treatment being rendered:

What is the DSMIIIR diagnosis? _____

Please list the Diagnosis code(s)

Current Axis V (GAF)? _____

What medications are currently being used? _____

_____

_____

Current frequency of visits? _____

What changes/revisions have been made to the treatment plan?

_____

_____

_____

_____

What goals have been accomplished? _____

_____

_____

Proposed discharge date: _____

Physician Signature: _____ **Date:** _____