Riverside University Health System – Behavioral Health

Assessment & Consultation Team
Quarterly Progress Report/Reauthorization Request

Consumer's Name: _____ Date of Report: _____

Consumer ID # (see client ID # on authorization): _____ Consumer DOB: _____

Therapist Name: _____ Ph#: _____

Agency Name: _____

M.H. (ACT) Clinician: _____ Ph#: _____

Social Worker's Name: _____ Ph#: _____

First Date of Service: _____ Quarterly Report: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

Reason for Initial Referral:

Services Provided: (Type: i.e.: Individual, Family, and dates of sessions attended)

Diagnosis: Treatment, goals, objectives, etc must be consistent with the current diagnosis. Put a "P" next to Primary Diagnosis.

ICD -10 Code: _____ _____

_____ _____

_____ _____

DSM: Axis I: _____ _____

_____ _____

_____ _____

Axis II: _____ _____

General Medical Conditions:

Treatment Issues Addressed / Assessment as related to DSM Diagnosis:

CONSUMER'S NAME_____

Progress on Goals: Describe the consumer's progress in meeting the previous goals (identified on the Assessment & Care Plan or the last Quarterly Report):

Goal #1:

Goal #2:

Recommendations/justification for ongoing services:

Current Goals for this Quarter: [must be observable/measurable & specifically focus on areas of impairment (family unit, health/safety, school, social, work) that enables this consumer to meet Medical Necessity.] Must include baseline and frequency. Children need only be "at risk" of impairment in the aforementioned areas.
Also include description of the method for achieving goals(s) and the consumer's responsibility.

Goal #1:

Target Completion Date: _____

Goal #2:

Target Completion Date: _____

Describe how symptoms currently impair functioning:

CONSUMER'S NAME_____

Current Medication(s) and Dosage(s):

Prescribed By:

PROPOSED TREATMENT: **Total Number of Sessions Used to Date:** _____

Psychiatric Evaluation:	_____	session(s) per ☐week / ☐month / ☐quarter for	_____	☐weeks / ☐months (☐15 / ☐30 mins)
Individual Therapy:	_____	session(s) per ☐week / ☐month / ☐quarter for	_____	☐weeks / ☐months (☐ 60 mins)
Group Psychotherapy:	_____	session(s) per ☐week / ☐month	_____	☐weeks / ☐months
Family Therapy:		session(s) per ☐week / ☐month / ☐quarter for		☐weeks / ☐months (☐30 mins)

Name of Participant(s) & Relationship to Consumer:

_____ Purpose: _____

_____ Purpose: _____

_____ Purpose: _____

_____ Purpose: _____

Collateral: ____ session(s) per ☐ week ☐/month/☐quarter for ____ ☐weeks/☐months (☐30 mins)

Name of Participant(s) & Relationship to Consumer:

_____ Purpose: _____

_____ Purpose: _____

_____ _____

Treating Therapist/Intern Signature w/license # or Intern designation **Date**

_____

Print Name

_____ _____

Clinical Supervisor's Signature and License **Date**

_____

Print Name

_____ _____

Physician's Signature **Date**

_____

Print Name

_____ _____

Consumer's Signature **Date**

_____ _____

Parent/Guardian's Signature (if minor)** **Date**

**(If "dependent" Court Minute Order can be substituted for parent/guardian signature-no foster parent, social worker or group home staff may sign for a minor in their care)

FAX COMPLETED REPORT TO: Assessment & Consultation Team (ACT) (951) 687-5819

