INTERFACE EAP – CLINICAL FEEDBACK FORM

VOICE: 800-324-4327 or 713-781-3364 SECURE CLINICAL FAX: 800-304-4838 or 713-781-4954

This form is used to provide Interface EAP with clinical information and to request authorization.

Patient's First Name: _____ **Case Number:** _____

Provider: _____ **Date Form Submitted:** _____

I. Date(s) of sessions covered in this report: _____

II. Diagnoses: _____

_____

III. Stressors: _____

IV. Current Symptoms And Severity: ☐ Symptoms in remission due to medication

_____

_____

V. Relevant History: ☐ No additional data since last clinical update

_____

_____

VI. Current Medications And Dosages: ☐ No current psychotropic medications

_____

_____

VII. Patient's Current Level Of Risk (*include data on history and any plan*):

A. Suicide:
[1] Probability: ☐ None ☐ Low ☐ Moderate ☐ High
[2] Plan: ☐ None Specific Plan: _____
[3] Intent: ☐ None Level of Intent: _____

B. Significant Violence Toward Others:
[1] Probability: ☐ None ☐ Low ☐ Moderate ☐ High
[2] Plan: ☐ None Specific Plan _____

VIII. Proposed Treatment Plan (*D & E must be completed for long-term cases*):

A. Estimated length of treatment: _____ ☐ Chronic condition -- indefinite treatment

B. Goals to be met before termination of treatment: _____

_____

_____

C. How are goals to be measured? _____

D. Progress since start of treatment? Completed _____ % of goals as evidenced by: _____

_____

_____

E. Anticipated step-down date: _____ Step-down frequency? _____

F. Patient's response to treatment ☐ Poor ☐ Marginal ☐ Fair ☐ Good ☐ Excellent

VIIII. Action Requested (*must be completed for authorization)*:

☐ Long Term Issue: Request use of Insurance Benefits (*uninterrupted care for duration of treatment*)
1. CPT Code: _____ Frequency: _____ Number: _____
2. CPT Code: _____ Frequency: _____ Number: _____

☐ Referral to: _____ For: _____

☐ Close case - No further treatment necessary