

# 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

**VIII. 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

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