Chemical Dependency Outpatient Treatment Plan

Please fax to: (541) 225-3667

Or mail to:
PacificSource
Attn: Health Services
PO Box 7068
Springfield OR 97475-0068

Please complete the *entire* form and fax or mail it to us. **Include current ASAM and intake assessment**. Missing information will delay the review process. If you have any questions or have a special request, please feel free to contact our Behavioral Health Team at (888) 691-8209.

▼ PATIENT

Last name: ____________________ First name: ____________________

Date of birth: ____________________ Member ID number: ____________________

▼ CONTACT/PROVIDER INFORMATION

Contact person:
Name: ____________________ Date: ____________________
Phone: ____________________ Extension: __________ Fax: ____________________

Treating Provider:
Name: ____________________ License type: ____________________
Phone: ____________________ Extension: __________ Fax: ____________________
Mailing address: ____________________
City/State/Zip: ____________________ TIN:____________________

▼ TREATMENT INFORMATION

Diagnosis code and description: ____________________

Number of visits requested: _______ **Requested time frame:** From:__________ To: __________

visits per week: __________ # hours per session: __________ Level of care: ☐ IOP ☐ Outpatient

Note: Preferred time frame per treatment plan is six months. If you need more time, please note reasons in the Comments section on this form or contact a Behavioral Health Team Case Manager.

▼ CLINICAL DATA (to support above diagnosis and treatment being provided)

Describe the progress for each ASAM Dimension. If there is lack of progress, describe how it is being addressed.

Dimension 1 — Acute intoxication and/or withdrawal: ____________________

Dimension 2 — Biomedical conditions and complications: ____________________

Continued on next page

▼ CLINICAL DATA (continued)

Dimension 3 — Emotional, behavioral, or cognitive conditions: ______________________________

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Dimension 4 — Readiness to change (current stage): ______________________________

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Dimension 5 — Relapse, continued use, or continued problem potential: ______________________________

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Dimension 6 — Recovery/living environment: ______________________________

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Has your patient had a mental health assessment? ☐ Yes ☐ No

List date of assessment, provider, resulting diagnosis, and treatment objectives to address areas of concern:

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Is your patient currently taking psychotropic medication? ☐ Yes ☐ No ☐ Not sure

List current medications: ______________________________

Type of prescribing clinician: ☐ PCP ☐ PMHNP ☐ Psychiatrist ☐ Other: ______________

Are you coordinating with the prescriber? ☐ Yes ☐ No

Is your patient involved with other types of providers/community services? ☐ Yes ☐ No

Describe coordination of care: ______________________________

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Describe after-care plans: ______________________________

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Comments: ______________________________

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