

**TREATMENT REQUEST FORM**

*Please Forward to:*

**St. John's Mercy Managed Behavioral Health  
(formerly, Unity Managed Mental Health)**

1000 Des Peres Road, Suite 200 C  
St. Louis, MO 63131

**Today's Date:** \_\_\_\_\_

Phone: (314) 729-4600/800-413-8008

Fax: (314) 729-4636

**Prior Authorization #:** \_\_\_\_\_

**Start Date:** \_\_\_\_\_

**INSURANCE: Please check the account that applies**

**MHP**\_\_\_ **Carpenters**\_\_\_ **LHI**\_\_\_ **IBEW IL**\_\_\_ **Machinists**\_\_\_

**Patient Name** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**SS# or MHP member ID** \_\_\_\_\_

**(Union Accounts use SS#)**

**Practitioner Name** \_\_\_\_\_

**Fax #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**RISK ASSESSMENT - Current Status**

**Suicide Ideation:** \_\_\_ Present \_\_\_ Not Present **Homicidal Ideation:** \_\_\_ Present \_\_\_ Not Present **Pregnant** \_\_\_Y \_\_\_N

**Substance Abuse:** \_\_\_ Present \_\_\_ Not Present **Domestic Violence:** \_\_\_ Present \_\_\_ Not Present

**FUNCTIONAL IMPAIRMENT SCALE:** [To be completed by all Providers – MD's use for 90806/07 services only]

**Rate level of severity as: 0=absent, 1=mild, 2=moderate, 3=severe**

	<b>Initial</b>				<b>Current</b>				<b>Goal</b>			
Agitation	0	1	2	3	0	1	2	3	0	1	2	3
Hyperactivity	0	1	2	3	0	1	2	3	0	1	2	3
Sleep	0	1	2	3	0	1	2	3	0	1	2	3
Appetite	0	1	2	3	0	1	2	3	0	1	2	3
Mania	0	1	2	3	0	1	2	3	0	1	2	3
Depression	0	1	2	3	0	1	2	3	0	1	2	3
Anxiety	0	1	2	3	0	1	2	3	0	1	2	3
Obsessive Compulsive Disorder	0	1	2	3	0	1	2	3	0	1	2	3
Eating Patterns (binge, anorexia)	0	1	2	3	0	1	2	3	0	1	2	3
Psychotic Process	0	1	2	3	0	1	2	3	0	1	2	3
Cognitive Process	0	1	2	3	0	1	2	3	0	1	2	3
Psycho/Social Relationships	0	1	2	3	0	1	2	3	0	1	2	3

**OTHER/COMMENTS:**

**CURRENT DIAGNOSIS**

**AXIS I** \_\_\_\_\_

**IV Psycho/Social Stressors** \_\_\_ Mild \_\_\_ Mod \_\_\_ Severe

**AXIS II** \_\_\_\_\_

**V GAF:** \_\_\_\_\_ High Past Year \_\_\_\_\_ Current

**AXIS III** \_\_\_\_\_

**REQUESTED # OF VISITS:** \_\_\_\_\_

**CURRENT MEDICATIONS**

<b>Name</b>	<b>Dose</b>	<b>Start Date</b>	<b>MD prescribing (if not self)</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**HAVE YOU COORDINATED TREATMENT WITH PRIMARY CARE?**

Yes \_\_\_\_\_ Patient Declines to Release \_\_\_\_\_ Patient does not have a PCP \_\_\_\_\_

I authorize the release of all information above including drug/alcohol treatment or use, AIDS/HIV or other communicable diseases, psychiatric treatment and/or test results to my PCP. I understand that I may revoke this authorization at any time, however, revocation will have no effect on any disclosures made before written revocation. My PCP is prohibited from making further disclosure of this information without my specific prior written consent.

\_\_\_\_\_  
PCP Name

\_\_\_\_\_  
Phone/Fax

\_\_\_\_\_  
Patient Signature / Date

Sig. On File