Patient Name: _____
Patient ID: _____
Date: _____

DUPLICATE THIS PAGE FOR ANY ADDITIONAL PROBLEMS

'ROBLEM # ___: _____

_____

_____

'reatment Goals [after each item selected, indicate outcome measures (i.e. "as evidenced by"]
___ Reduce Risk Factors of: _____
___Reduce Major Symptoms of: _____
___ Ameliorate Functional Impairments of: _____
___ Develop Coping Strategies to Deal with Stress of: _____
___ Stabilize (short term) Crisis of: _____
___ Maintain (long term) Stabilization of Symptoms of: _____
___ Medication referral to: _____
___ Other _____

lanned Interventions-Patient Participation (must be consistent with treatment goals):
__ Assertiveness Training
__ Anger Management
__ Affect Identification and Expression
__ Cognitive Restructuring
__ Communication Training
__ Grief Work
__ Imagery/Relaxation Training
__ Parent Training
___ Problem Solving Skills Training
___ Solution Focused Techniques
___ Stress Management
___ Supportive Therapy
___ Self/Other Boundaries Training
___ Decision Option Exploration
___ Pattern Identification and Interruption
__ Engage Significant Others in Treatment: _____
__ Facilitate Decision Making Regarding: _____
__ Monitor: _____
__ Teach Skills of: _____
__ Educate Regarding: _____
__ Assign Readings: _____
__ Assign Tasks of: _____
__ Referrals Planned: _____
__ Preventive Strategies: _____
__ Obstacles to Change: _____

ARGET DATE FOR GOAL ACCOMPLISHMENT _____

y therapist and I have developed this plan together, and I am in agreement to working on these issues and als. I understand the treatment goals that were developed for my treatment.

ıtient Signature _____ Date _____

erapist Signature _____

Initial Evaluation Template

Patient's Name/ID#: _____

Source of Information: (patient, family, other): _____

Presenting Problem (include onset, duration, intensity):

_____

_____

_____

_____

_____

_____

_____

_____

Precipitating Event (why treatment now?): _____

_____

_____

_____

Mental Status (circle appropriate items):

Appearance: Appropriate Inappropriate Disheveled Unclean Bizarre
Affect: Appropriate Inappropriate (describe): _____
(sad, angry, anxious, superficial, restricted, labile, flat)
Orientation: Oriented Disoriented (to person, place, time, date, day, situation)
Mood: Normal Other_____ (euthymic,depressed, irritable, angry)
Thought Content: Appropriate Inappropriate
Thought Process: Logical Tangential Illogical
Speech: Normal Slurred Slow Pressured Loud
Motor: Normal Excessive Slow Other_____
Intellect: Average Above Below
Insight: Present Partially Present Absent
Judgment: Normal Impaired
Impulse Control: Normal Impaired
Memory: Normal Impaired Immediate Recent Remote
Concentration: Normal Impaired
Attention: Normal Impaired
Behavior: Appropriate Inappropriate (anxious, agitated, guarded, hostile, uncooperative, drowsy, hyperactive, psychomotor retarded)
Thought Disorder: No Problem Delusions Grandiosity Paranoia
Ideas of reference Tangential Loose associations
Perseveration Confusion Thought blocking
Obsessions Flight of ideas

Initial Evaluation Template

Patient's Name/ID#:_____

Children and Adolescents *ONLY*:

Developmental History (developmental milestones met early, late, normal):_____

_____

Perinatal History (details of labor/delivery):_____

_____

Prenatal History (medical problems during pregnancy, mother's use of medications):_____

_____

Referral to PREVENTIVE SERVICES for all patients (as appropriate):

___Relapse prevention
___Stress management
___Wellness programs
___Lifestyle changes
___Referrals to community resources
___Legal aid
___Financial aid
___Pastoral care
___Medical/Psychiatric Assessment
___Others: (describe)

Diagnostic Impression:
Axis I:
Axis II:
Axis III:
Axis IV: _____Mild _____Moderate _____Severe
Nature of Stressors:___Family ___School ___ Work ___Health___ Other: (describe)
Axis V:
Current GAF:
Highest GAF:

Initial Transition/Discharge Plan: _____

FU Appt:_____

Clinician Signature:_____ Date: _____

Drew Alikakos, M.S./Licensed Psychologist
PROGRESS NOTE

CLIENT NAME: _____ SS#_____

DATE of Session: _____

R.T.C

_____
Signature

DATE of Session: _____

R.T.C.

_____
Signature

DATE of Session: _____

R.T.C.

_____
Signature

PROBLEM GOAL MODALITY TIME

TR Plan: _____
DATE:

Clinician Communication Form

Patient Name: _____ Patient Date of Birth: _____

Clinician Name: _____
Clinician Address: _____
_____

Clinician Phone/Fax: _____

Dear Colleague:

I saw the above-named patient, who gave an authorization to release the following information, on _____ for_____
(Date). (Reason/Diagnosis)

Brief Summary (if indicated):

_____
_____
_____

Current Treatment (interventions by sending practitioner):
• Psychotherapy • Patient Refused Medication
• Medication(s) Prescribed: _____
_____
_____
_____

Lab Tests: •CBC •Thyroid Studies • Chem Profile • EKG
• Lipid Profile • Serum drug level (specify drug)_____
Other: _____
Diagnostic Tests: _____

Treatment terminated (date/reason): _____
_____
_____

Other Treatment Recommendations (interventions requested of receiving practitioner):
_____
_____
_____

The patient has • has not • received a copy of this form. If you have any questions or would like additional information, please contact me. Thank you.

Clinician Signature: _____ Date Sent/Faxed: _____
Clinical Phone #: _____

Drew Alikakos, M.S.
Licensed Psychologist

811 West Chester Pike
West Chester, PA 19382
Office 610-696-0325

Cell 610-308-2290

Date:

Dear _____

You missed your last appointment. If we do not hear from you in the next 30 days, your case will be closed and we will assume you no longer desire treatment here at this facility. If your case is closed you may re-open at anytime by calling (610) 308-2290.

If you need to re-schedule from your last appointment, please call (610) 308-2290.

I would also like to take this time to let you know we also have other therapist available at this facility.

Thank you for your time and consideration.

Drew Alikakos, M.S.
Addiction and Psychological Therapy

Discharge Summary Template

(Must be completed within 60 days from last visit)

Patient's Name/ID#: _____ **Date:** _____

Reason for Termination (was patient in agreement with termination at this time?)

_____

_____

_____

If patient did not return for scheduled appointment, was/were attempt(s) made to contact patient to re-schedule?

_____

_____

_____

Discharge Medications: _____

_____

Discharge DSM IV

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

Referral Options (if treatment goals were not met, appropriate referrals must be made)

1. _____
2. _____
3. _____

Referred to preventive services as appropriate (for example):

___Relapse prevention
___Stress management
___Wellness programs
___Lifestyle changes
___Referrals to community resources
___Legal aid
___Financial aid
___Pastoral care
___Medical/Psychiatric Assessment
___Others: (describe)

If patient has become suicidal, homicidal or unable to conduct activities of daily living during course of treatment, was patient referred to appropriate level of care? Explain:

_____

_____

_____

Clinician Signature: _____ Date: _____

811 West Chester Pike
West Chester, PA 19382

This document was developed by Magellan Health Services Southeast Care Management Center

Patient's Name/ID#: _____

Patient Strengths/Weaknesses as observed in this visit: _____

_____

_____

_____

Preliminary Discharge Plan: _____

_____

<u>Referral to Preventive Services</u> (as appropriate):

___Relapse prevention
___Stress management
___Wellness programs
___Lifestyle changes
___Referrals to community resources
___Legal aid
___Financial aid
___Pastoral care
___Medical/Psychiatric Assessment
___Others: (describe)

Interventions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Follow-Up Appt: _____

Clinician Signature: _____

Date: _____

811 West Chester Pike
West Chester, PA 19382