

**HARMONY HEALTHCARE  
TREATMENT PLAN/CONTINUED AUTHORIZATION REQUEST**

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Patient Name:

Date of Birth:

Age:

M or F  
(circle one)

Insurance:

ID #:

Current

Symptomatology (substantiating a DX):

  
  

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Medications, Dosage and Frequency:

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Progress (related to treatment goals) since last update or Termination Summary: (use separate sheet if necessary)

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A: Goals

- 1.
- 2.
- 3.

B: Objective Outcome Criteria (by which goal achievement is measured)

- 1.
- 2.
- 3.

C: Planned Interventions

- 1.
  - 2.
  - 3.
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Diagnosis - Axis I through V, DSM - IV

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: Specify: \_\_\_\_\_

Axis V: Current GAF \_\_\_\_\_ Highest GAF past year \_\_\_\_\_

Was patient screened for Substance Abuse? Yes \_\_\_\_\_ No \_\_\_\_\_ Symptoms listed above \_\_\_\_\_ No problem indicated \_\_\_\_\_ (Please check one)

Date/First Visit: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_ # of Sessions to Date in TX Episode : \_\_\_\_\_ Frequency: \_\_\_\_\_

Estimated Total Number of Sessions to Complete Treatment (Specify): \_\_\_\_\_ # Sessions Requested \_\_\_\_\_

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent if under 18 years of age)

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