**CLINICAL INFORMATION REQUEST FORM**

**Instructions:**

* Complete one clinical request form per patient; all fields must be completed.

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| --- | --- | --- | --- |
| **Date:** | | | |
| **Organization:** | | | |
| **Organization Address:** | | | |
| **Organization City:** | **Organization State:** | | **Organization Zip Code:** |
|  | | | |
| **Patient Name:** | | **Patient Date of Birth:** | |
| **Servicing Practitioner Name:** | | **Servicing Practitioner License:** | |
| **Servicing Practitioner NPI:** | | | |
| **Servicing Practitioner Phone Number:** | | | |

|  |  |
| --- | --- |
| **Treatment Plan & Goals** | |
| **Primary Diagnosis:** | **ICD-10 Code:** |
| **Outline or Describe Associated Symptoms being treated:** | |
| **Treatment Goal (Specific, Measurable):** | |
| **How are treatment goals being measured (standardized or evidenced based clinical scores or tools, etc.)?** | |
| **Outline Progress towards Goal (including any changes in symptoms and response to treatment as measured by the method outlined above, including baseline and current clinical scores):** | |
| **Current Status (Mark One):**  **Resolved  Significant Progress  Moderate Progress  Little Progress  No Progress  Declining** | |
| **If patient is not progressing toward meeting therapeutic goals:** | |
| 1. **Describe the reason for lack of progress:** | |
| 1. **What changes in treatment (Treatment Modality, Specific, Measurable Goals, and Interventions) are being made to help patient progress in treatment?:** | |