**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:** |

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| **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:**
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| 1. **What changes in treatment (Treatment Modality, Specific, Measurable Goals, and Interventions) are being made to help patient progress in treatment?:**
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