

Capital Area

BHRS Interagency/Prescriber Collaboration Form for BHRS Psychological/Psychiatric Evaluations

Date: _____

Date of most current evaluation or last time child seen by Evaluator: _____

Member Information

Name: _____

Provider: _____

DOB: _____

Provider Contact: _____

MA #: _____

Phone: _____

Prescriber Name: _____

Prescriber Phone: _____

Summary of ISPT Meeting Recommendations:

ISPT Recommendations Gathered By: Meeting Phone contact with each member

Please check and describe all relevant clinical changes that have occurred since the most recent psychiatric/psychological evaluation or interagency service team meeting:

Symptoms and/or behaviors have **increased**

Please describe:

Symptoms and/or behaviors have **improved**

Please describe:

Additional services have been initiated

Please describe:

Additional natural supports have been identified and actively engaged

Please describe:

Capital Area

Method of coordinating recommendations between ISPT and Prescriber: *(if Prescriber not at ISPT Meeting)*

Diagnosis *(must be filled out in entirety)*

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Final Recommendations and Prescription for Services:

- Same as reported** on current psychiatric/psychological evaluation
- Revised** following coordination with interagency team

Please list **recommendations** *(include all recommendations not just BHRS):*

Services delivered during the course of authorization-please list units delivered by authorized service type:

MT _____ BSC _____ TSS _____

If prescription is being **amended**, please explain why:

Member/Family member input:

Prescriber Signature: _____ Date: _____

Member/Family Signature: _____ Date: _____

(Required: Used to denote concurrence with recommended changes to prescription)