



PacificSource Community Solutions, Inc.  
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## Behavioral Health Outpatient PreApproval Request

**Please fax the completed form to (541) 330-4910.**

Patient Information			
Last Name:		First Name:	
Date of Birth:		Member ID Number:	
Contact/Provider Information			
Contact Person:	Name:		Date:
	Phone:	Extension:	Fax:
Treating Provider:	Name:		License Type:
	Mailing Address:		
	City:		State:
	Phone:		Fax:
Treatment Information			
DSM diagnosis (Axis I code and disorder):			
Severity Index (GAF/C-GAS):			
Visits Requested:		Start Date:	
		End Date:	
Clinical Data (to support above diagnosis and treatment being provided)			
<b>Current Symptoms:</b>			
<input type="checkbox"/> Appetite (up/down)	<input type="checkbox"/> Excessive fear or worry	<input type="checkbox"/> Racing thoughts	
<input type="checkbox"/> Acting out at school/home	<input type="checkbox"/> Feeling worthless/guilty	<input type="checkbox"/> Recurring unwanted thoughts	
<input type="checkbox"/> Cognitive impairment	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Reliving traumatic events	
<input type="checkbox"/> Delusional ideas	<input type="checkbox"/> Impaired judgment/insight	<input type="checkbox"/> Repetitive behaviors	
<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Impairment in concentration	<input type="checkbox"/> Self-harm behavior	
<input type="checkbox"/> Disorganized/bizarre thoughts	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Sleep (up/down)	
<input type="checkbox"/> Dissociation	<input type="checkbox"/> Loss of interest	<input type="checkbox"/> Substance use/abuse	
<input type="checkbox"/> Elevated or irritable mood	<input type="checkbox"/> Physical activity (up/down)	<input type="checkbox"/> Suicidal/Homicidal thinking	
<b>Functional domains that are currently impaired and are treatment targets:</b>			
<input type="checkbox"/> Activities of daily living	<input type="checkbox"/> Job/School performance	<input type="checkbox"/> Sexual functioning	
<input type="checkbox"/> Disability	<input type="checkbox"/> Marriage/Relationships/Family		<input type="checkbox"/> Sleep habits
<input type="checkbox"/> Finances	<input type="checkbox"/> Physical health		
<input type="checkbox"/> Friendships/peers	<input type="checkbox"/> Pleasurable activities		

