Windstone Behavioral Health

Practitioner's Name and Licensure: _____

Psychiatry

Treatment and Communication Form
(MD/DO/NP)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____ **Fax #:** _____

Patient's Name: _____ **Date of Birth:** _____ **Date of Service:** _____

Current Medication (dosage/how often) _____

_____

Response to Medication (effective/not effective, etc.) _____

_____

Side effects or negative drug interactions ○ **No** ○ **Yes (if yes please specify):** _____

_____

Patient's compliance with medication since last session: ○ **No** ○ **Yes (if no please explain):** _____

_____

Medication Changes (dosage / how often): _____

_____

DSM-5 Diagnoses:

Axis I: ***Alpha-Numeric Code:*** _____ ***Description:*** _____

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Axis I: ***Alpha-Numeric Code:*** _____ ***Description:*** _____

Change in Diagnosis from prior visit: ○ **Yes** ○ **No**

Revised Diagnosis: _____

Your request will be processed as a standard request; unless specified as URGENT (circle if urgent & document).

All URGENT requests require telephonic notification to 1-888-738-7172 upon submission of this form.

Documentation: _____

Windstone will authorize up to six medication management sessions, 1 time per month, unless medical necessity indicates otherwise. If increased frequency is required, please describe clinical justification: _____

_____

_____

PCP Name: _____ **PCP Fax #:** _____

Please fax this form to (714) 644-8244

This document will be submitted to PCP in accordance with Windstone policies and procedures.

Practitioner's Signature: _____ **Date:** _____

The use of this form is for PCP communication only when requesting additional sessions