Windstone Behavioral Health

Practitioner's Name and Licensure: _____

Psychotherapy

Treatment and Communication Form

(PhD/PsyD/LCSW/MFT)

Address: _____

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

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

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

Type of therapy to be provided: _____

_____

Patient is compliant: ○ **Yes** ○ **No (if no please explain):** _____

_____

DSM-5 Diagnoses:

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

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

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

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

Revised Diagnosis: _____

Treatment Report (TR):
Windstone will authorize up to six sessions per request allowing us to communicate with member's PCP.

- ☐ **(90832) Individual therapy (30 Minutes)** **# Sessions Requested** _____ **Frequency** _____
- ☐ **(90834) Individual Psychotherapy (45 Minutes)** **# Sessions Requested** _____ **Frequency** _____
- ☐ **(90853) Group Therapy** **# Sessions Requested** _____ **Frequency** _____

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: _____

Patient has signed release of information to PCP and this form may be forwarded to PCP? ○ **Yes** ○ **No**

Practitioner's Initials: _____

If patient does not wish to release information to PCP, patient signature is required:

_____

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