Mental Health Evaluation/Treatment Request

To: Nueva Vida Behavioral Health Associates, 9500 Tioga Dr., SATX 78230 (Fax #855-616-0829)

Re: Patient's Name:_____
Date of Injury:_____
Claim #:_____

This form requests mental health evaluation/treatment for the above patient. Please provide Nueva Vida with your evaluation report of his/her current psychological functioning related to the following concerns:

_____AGITATION
_____ANXIETY
_____SIGNIFICANT MENTAL STRESS
_____DEPRESSION
_____POST TRAUMATIC STRESS DISORDER
_____MENTAL CONFUSION-including disrupted through process in attention, concentration, memory, and/or problem solving
_____PHYSICAL/SOMATIV SYMPTOMS OR PSYCHOPHYSIOLOGICAL SYMPTOMS RELATED TO PATIENT AFFECT AND STRESS STATE-including multiple vague physical symptoms, tension headaches, high blood pressure, headaches/mixed, sleep disturbance, etc.
_____SELF-DESTRUCTIVE THOUGHTS OR SUICIDAL IDEATION
_____SLEEP DISTURBANCE
_____SUICIDAL IDEATION
_____ERECTILE/SEXUAL DYSFUNCTION
_____ALTERATION IN BLADDER/BOWEL FUNCTION

The following concerns address the patient's mental status having an adverse impact on his/her ability to participate in, or respond to appropriate medical treatment.

_____ALCOHOL USE
_____DEFICIT OR LACK OF MOTIVATION AND EFFORT
_____DIFFICULTY PARTICIPATING IN APPROPRIATE REHABILITATION EFFORTS
_____EXCESSIVE HEALTH CARE-persistent, excessive use of health care system or excessive inappropriate seeking of diagnostic testing/surgical intervention
_____EXCESSIVE SYMPTOMS
_____HOSTILE/RESISTENT BEHAVIOR-hostile or disgruntled patient behavior externalized to others, secondary to pain
_____MEDICATION COMPLIANCE DIFFICULTIES
_____MEDICATION MISUSE
_____NEUROPSYCHOLOGICAL/HEAD INJURY
_____NEUROFEEDBACK TREATMENT
_____PAIN COMPLAINTS-patient's pain extends beyond the primary intervention phase (0-3 months) with continued, significant impairment in daily functioning and failure to return to work and/or progress adequately in health care treatments
_____POST TRAUMATIC STRESS DISORDER EVALUATION/TREATMENT
_____SYMPTOM EXAGGERATION AND/OR MALINGERING
_____TREATMENT PLANNING-regarding need for mental health treatment or comprehensive rehabilitation/pain management program/surgical intervention
_____VOCATIONAL EVALUATION/PLANNING/WORK HARDENING PROGRAM
_____SURGICAL CLEARANCE _____Trial Spinal Cord Stimulator
_____ Intrathecal Pump
_____ Orthopedic Surgery
_____ SOCIAL SERVICE NEEDS (specify) _____

_____ _____
Doctor's Signature Date