



One Monarch Place · Suite 1500
Springfield, MA 01144-1500
413-787-4000 · 800-842-4464

DIALECTICAL BEHAVIOR THERAPY EXTENDED REVIEW FORM

BEHAVIORAL HEALTH DEPARTMENT
PHONE: (413) 787-4000 EXT. 5028 FAX: (413) 233-2800

Please complete thoroughly. Send completed form to HNE Behavioral Health Department for review and decision.

MUST ENCLOSE RELEVANT CLINICAL DOCUMENTATION TO SUPPORT THIS REQUEST

Provider Name: _____ Office Phone: _____

Clinician Name: _____ Phone(s): _____

Member Name: _____ HNE ID: _____

Request for additional treatment Start Date: _____ End Date: _____

Sequence of Modules Planned: _____

Discharge Summary End Date: _____

Explain changes in diagnosis, living situation or providers: _____

Problem Area #1: _____

Progress on Treatment Goal(s): None Limited Moderate Good

Problem Area #2: _____

Progress on Treatment Goal(s): None Limited Moderate Good

Problem Area #3: _____

Progress on Treatment Goal(s): None Limited Moderate Good

Problem Area #4: _____

Progress on Treatment Goal(s): None Limited Moderate Good



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EXTENDED REVIEW FORM (PAGE 2)**

COMPLETE THE FOLLOWING ONLY IF THE TREATMENT HAS ENDED

Discharge Diagnosis:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

After Care Plan Including Medications: _____

Outpatient Appointments:

Therapist: _____ Appointment Date: _____
Psychiatrist: _____ Appointment Date: _____
Other Provider: _____ Appointment Date: _____