Halcyon Behavioral
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Admin Phone: (855) HBI-4HLP
Member Phone: (888) 425-4800
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PSYCHIATRIC TREATMENT REPORT

Patient Information

Name: ______________________________________ Date of Birth: _____________ Age: ____ Sex: ☐ M ☐ F

Insurance ID#: ________________________ Insurance Plan/Employer: _________________________________

Diagnosis (ICD-10): ____

Current Symptoms (within past 3-4 weeks):

____

Recent Labs:

____

Current Medications: (If on a controlled substance, please attach CURES Report)

Name	Dosage	Frequency	Date Started	Date Changed	Plan

Are any of medications listed above being prescribed off-label? ☐ YES ☐ NO

Response to Medication:

____

Other Orders/Disposition:

____

Coordination of Care with: ☐ Therapist ☐ PCP ☐ Specialist Physician ☐ Substance Abuse Program ☐ Mental Health Program ☐ Other: ________________________________

**Please attach any recent survey scores (e.g. PHQ-9, Ham-D 24, etc.) or additional documentation for review*

My signature below confirms the information provided is accurate and I am providing the requested services

Provider Signature:___________________________________ Date: __________________________

Provider Name (Printed): ____________________________________ Phone: _____________ Fax: _____________