QualChoice®

Plan of Care

PLEASE PRINT

SECTION I: PATIENT INFORMATION			
PATIENT'S NAME			DATE OF BIRTH (MM/DD/YYYY)
QUALCHOICE ID NUMBER	DATE OF INITIAL VISIT (MM/DD/YYYY)		
BRIEF PSYCHIATRIC HISTORY			
CURRENT SYMPTOMS			

SECTION II: MEDICAL, PSYCHIATRIC, SUBSTANCE USE DISORDER INFORMATION			
AXIS I			
AXIS II			
AXIS III			
AXIS IV			
AXIS V			
MEDICATION AND DOSAGE			
TREATMENT PLAN			

SECTION III: GOALS/PROGRESS WITH GOALS FOR CONTINUED TREATMENT	
1.	
2.	
3.	
NUMBER AND FREQUENCY OF VISITS REQUESTED	NUMBER OF SESSIONS USED TO DATE

SECTION IV: PROVIDER INFORMATION			
PROVIDER NAME	PROVIDER QUALCHOICE ID NUMBER	PROVIDER PHONE NUMBER	
PROVIDER ADDRESS *(REQUIRED)*	CITY	STATE	ZIP
PROVIDER SIGNATURE *(REQUIRED)*		DATE (MM/DD/YYYY)	

SECTION V: INSTRUCTIONS

PLEASE FAX OR MAIL COMPLETED FORM TO:

QualChoice
ATTN: Quality and Care Management Department
12615 Chenal Pkwy, Ste 300 • Little Rock, AR 72211
Fax: 501.228.9413 or 800.228.9413