# *Island Group Administration, Inc.*

Corporate Offices
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## Initial Outpatient Treatment Report

Patient Name:_____ Date of Birth:_____ Male/Female

Address:_____

Insured's Name:_____ Relationship:_____

Date Treatment Began:_____ Continuing: **YES** **NO** Termination Date:_____

ID #:_____

Diagnosis:

1_____ 2_____

3_____ 4_____

Describe Patient's Current Condition:_____

_____

**Circle Below**

**Therapy Type:** ***INDIVIDUAL*** ***GROUP*** ***FAMILY*** ***MED MANAGEMENT***

**Frequency:** ***WEEKLY*** ***MONTHLY*** ***OTHER***_____

**Duration in Minutes:** ***15*** ***30*** ***45*** ***OTHER***_____

Treatment Goals & Estimated Time of Treatment:_____

_____

Adjunctive Therapies Used (Specify Type/Purpose):_____

_____

Current Medications (Please list Drug, Dosage and Date Begun):_____

_____

Collateral Contacts (Sessions including a Significant Other/Family Member-Specify Relation and Purpose:

_____

Notes:_____

_____

**TO THE BEST OF MY KNOWLEDGE, THIS PATIENT HAS NOT BEEN MANDATED BY A COURT TO ATTEND SESSIONS FOR THE ABOVE DIAGNOSIS. INITIALS_____**

Provider Name:_____Degree_____

Address:_____

Phone:_____ Fax_____ Email_____

TAX ID_____

**Preferred Method to Receive Authorization (circle one) FAX EMAIL MAIL**