Integrated Therapy Solutions of Oklahoma, LLC
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Outpatient Staffing and Assignment

Date Requested: _____ Requesting Provider: _____

Client Name: _____ Age/Sex: _____ Location: _____

Insurance Type: ☐ **SoonerCare** ☐ **Private Insurance (which insurance)** _____ ☐ **Cash/Intern: $**_____

Presenting Problems: _____

What is the client availability for services? ☐ Days ☐ Evenings ☐ Weekends ☐ Other _____
How many hours/times a week is client requesting to be seen: _____

Types of Services Requested: ☐ ***Home Based*** ☐ ***Office Based*** ☐ ***Telehealth***

☐ *Individual Therapy* ☐ *Family Therapy* ☐ **CM/Care Coord./BHRS**

Does anybody in the home smoke? If Yes, please explain: _____

Are there any pets in the home? If Yes, please explain: _____

Does the client/family have a preference regarding providers?

_____

Is there an active Treatment Plan? ☐ Yes ☐ No If yes – when does it expire? _____

If No, a treatment plan will need to be completed within two pre-auth sessions. (UNLESS an extension is needed)

Additional Comments/Info: _____

_____

_____

_____

Date Assigned: _____

Assigned to: _____