DESERET MUTUAL
BENEFIT ADMINISTRATORS

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DESERET HEALTHCARE CLINICAL INFORMATION FORM

(To be completed by therapist.)

Date: _____

Patient Name: _____

Policy Number: _____

DSM IV Diagnosis (Indicate if this is a change from the original diagnosis.)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Beginning Therapy _____ Present _____ Highest Past Year _____

Theraputic Interventions: _____

_____

_____

_____

Current Treatment Objectives (as quantitative or measurable as possible): _____

_____

_____

_____

_____

Progress Towards Accomplishment of Treatment Objectives: _____

_____

_____

_____

_____

Is the patient on medication? ❑ Yes ❑ No

Was the medication prescribed by a psychiatrist? ❑ Yes ❑ No

Therapist Name & Credentials: _____

PLEASE PRINT

Telephone Number: _____ **License Number:** _____