

Outpatient Provider: _____

Provider Treatment Plan Recommendations to Mental Health Board
(Outpatient Provider – Neb. Rev. Stat. 71-932)

Name of Person: _____

Address: _____

To: The Mental Health Board of the Fourth Judicial District, Douglas County, Nebraska

As a qualified mental health professional in compliance with Neb. Rev. Stat. 71-906, it is in my opinion that this patient meets diagnostic criteria for the following mental disorders and is in need of treatment as stipulated below:

Diagnoses:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

The Least restrictive treatment alternative would be:

Projected timelines, immediate and long-term, to achieve outpatient treatment goals:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Progress since the last report:

Name of Person: _____
Case Number: _____
Date of Birth: _____

Continuity of Care

The undersigned will continue to be the provider of record for this person and will continue to provide care until such time as the care has been transferred to another provider.

The undersigned will provide reports to the Mental Health Board every 90 days for a period of a year and every six months thereafter.

___ The undersigned has made arrangements to transfer the care of this person to:

Provider Name: _____
Address: _____
Phone: _____

___ The Patient's next (first) appointment is scheduled for:

Date: _____
Time: _____

The undersigned agrees to continue caring for this person until care is initiated with the new provider and the new provider has filed an acceptance of transfer with the Douglas County Board of Mental Health.

Clinician Name (print): _____
Title: _____
Phone Number: _____
Fax Number: _____
Facility: _____
Address: _____
City, State, Zip Code: _____

Signature: _____
Date: _____

IMPORTANT – PLEASE FILL OUT THE ENTIRE FORM