WHITMAN COUNTY LEOFF I BOARD
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(509) 397-5246
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HEALTH CARE PROVIDER'S TREATMENT PLAN

This form to be completed by providers of mental health, chiropractic and substance abuse treatment exceeding one month or in the case of additional medical services continuing more than two (2) visits for the same condition. To be mailed directly to member's employer/employer retired from within two weeks of initiation of treatment.

Patient: _____ SSN: _____
Employer/Retired from: _____ Physician/Provider: _____
Physician/Provider's Address: _____
_____

The treatment plan needs to be designed as an **individualized** plan to meet the unique treatment requirement of the patient while including, but not limited to, the categories suggested below. Please feel free to attach additional sheets as necessary.

Diagnosis:
Current medical diagnostic information (for mental health condition DSM III-R 5 digit code plus other axes involved and any relationship to the condition).

_____
_____
_____

Significant History:

_____
_____
_____

Prescribed Medication:
(Dosage, frequency, side effects, estimated length of treatment).

_____
_____
_____

Description of Treatment or Therapy:
(Treatment modality, frequency, length of treatment session, estimation of duration, approximate recovery time, criteria indication progress, additional professionals/therapists providing supplemental or alternative treatment services).

_____
_____
_____

_____ I have attached an additional sheet.

The services rendered by me and the medication, appliances or other therapies, which I prescribed, were necessary medical services in view of the patient's diagnosis and condition.

Signature of Provider: _____ Date: _____

WCLIB #5