2525 N. 117th Avenue
Suite 100
Omaha, NE 68168

Disease Management Referral

Patient Name_____ DOB_____

Clinician Name_____ Date _____

Baseline PHQ-9 Results

History:

- ☐ New Episode
- ☐ Established Case

Total Symptoms: _____ Total Score: _____

Suicidal Ideation: Patient response to question #9

- ☐ 0
- ☐ 1*
- ☐ 2*
- ☐ 3*

*If response/score is anything but "0" then a suicide assessment should be completed to determine if active thoughts/active suicidal ideation is present and take action consistent with protocols approved by his/her health care organization.

Treatment Selected:

☐ Medication :

Med: _____ **Dose**_____ **Frequency**_____

Med: _____ **Dose**_____ **Frequency**_____

☐ Psychological counseling referral provided

☐ Requesting Care Coordinator assistance to provide counseling referral

Additional Comments:

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