Print Form

IDAHO CRIME VICTIMS COMPENSATION PROGRAM

Initial Treatment Plan
Medication Management

CV#: _____ Patient's Name: _____
Parent/Guardian: _____ Tax I.D. #: _____
Physician's Name: _____
Name of coordinating Therapist: _____
Name of Facility: _____
Are you a provider under the following programs?

☐ Medicaid ☐ Medicare ☐ TriCare Other _____
☐ Blue Cross ☐ Indian Health Services ☐ Blue Shield

Indicate what sources of payment are available to the patient: _____
Date treatment began: _____ Number of sessions to date: _____
Are you providing individual psychotherapy to this patient? ☐ Yes ☐ No

1. **Please describe the presenting symptoms or conditions for which the patient is seeking treatment.**

2. **Does the patient have a history of previous health conditions that have required medication?**
☐ Yes ☐ No If so, indicate approximate dates of treatment, reasons for the medication, and results of the treatment.

3. **Please provide a brief description of the crime as related to you, including the source of the information (i.e. patient, parent or other).**

4. **Please describe any pre-existing conditions that are present that require medication to manage and to what extent these conditions were exacerbated by the crime**.

5. **Please list any medications that the patient was taking at the time of your assessment.**

Medication	Reason for Medication	Dosage	Duration

6. **Indicate percentage of medication management you are providing for any pre-existing or non-crime related conditions.**

_____ %

7. **Describe the symptoms/conditions you are treating that are a <u>direct</u> result of the crime.**

8. **Indicate percentage of medication management you are providing for any conditions that are a direct result of the crime.**
(Percentages from #6 and #8 should equal 100%) _____ %

9. **Please indicate how often you will see this patient.** _____ **per** _____

10. **List below the medications you are prescribing and what symptoms/conditions they are treating, and whether that prescription is for conditions that are a <u>direct</u> result of the crime.**

Medication	Symptoms/Conditions being treated	Crime Related Percentage of Rx

11. **I certify that the information provided in this treatment plan is true and accurate. I acknowledge that if the alleged offender is convicted, the Program will request the criminal court to order the alleged offender to pay restitution to reimburse the Program for expenses paid on behalf of the patient. I further acknowledge that this document may be submitted as evidence and that I may be called to testify regarding the treatment outlined in this plan.**

Signature of Physician _____

Date _____