Outpatient Behavioral Health Outcome Tool Selection Form

Fax to: 888-977-0776
For *Tufts Health Unify*, fax to: 781-393-2607

If you are a multisite organization, please only submit one form for the entire organization.

Provider information

Provider type ☐ Individual practitioner or non-hospital-based group ☐ Facility or hospital-based group

Practice name _____

Practice address _____

City _____ State _____ ZIP _____

Provider name _____ Title _____

Email address _____

Tufts Health Public Plans-approved assessment tools

Please indicate all tools you have chosen to implement.

- ☐ Adolescent Treatment Outcomes Module (ATOM)
- ☐ Behavioral and Emotional Rating Scale (BERS)
- ☐ Behavior and Symptom Identification Scale (BASIS)
- ☐ Brief Psychiatric Rating Scale (BPRS) – Adult and child
- ☐ Brief Symptom Inventory (BSI)
- ☐ Child-Adolescent Functional Assessment Scale (CAFAS/PECFAS)
- ☐ Child and Adolescent Needs and Strengths (CANS)*
- ☐ Child Behavior Checklist (CBCL)
- ☐ Connor's Rating Scales – Revised (CRS-R)
- ☐ Current Evaluation of Risk and Functioning – Revised (CERF-R)
- ☐ Global Appraisal of Individual Needs (GAIN)
- ☐ Methadone Treatment Quality Assurance System (MTQAS)
- ☐ Patient Health Questionnaire (PHQ)
- ☐ Personal Experience Inventory (PEI, PEI-Adult)
- ☐ Quality of Life Inventory (QOLI)
- ☐ SF8, 12, 36
- ☐ SOCRATES
- ☐ Symptom Checklist-90 – Revised (SCL-90-R)
- ☐ Treatment Outcome Package (TOP, TOP-SA)
- ☐ Youth Outcome Questionnaire (YOQ)
- ☐ Other: _____ *Please also fill out the alternate assessment tools section below.*

* The CANS assessment is required for all *Tufts Health Together* members younger than 21.

Alternate assessment tools *If you have checked "other" above, please fill in detail below.*

List the alternate assessment tools you are requesting approval to use: _____

With which population(s) will you administer the tool?

- ☐ Children
- ☐ Adolescents — mental health
- ☐ Adolescents — substance use
- ☐ Adults — mental health
- ☐ Adults — substance use

Describe why you want to use an alternate assessment tool instead of a Tufts Health Public Plans-approved assessment tool:

I understand that the chosen instrument(s) are to be administered to all Tufts Health Public Plans members receiving treatment and that the information I have provided is subject to on-site or telephonic review. I also understand that if there are changes to the information I have provided, it is my responsibility to notify Tufts Health Public Plans by updating the information on this page and resubmitting this form. I verify that all statements are accurate to the best of my knowledge.

Provider signature _____ Date _____