

**Date:** [Insert Date]

**RE:** History of Failed Outpatient Treatments

**Patient Name:** [Patient First and Last Name]

**Date of Birth:** [MM/DD/YYYY]

**Policy/ID Number:** [Insert ID Number]

To Whom It May Concern,

This letter serves to document the outpatient treatment history for [Patient Name] regarding the diagnosis of [Insert Diagnosis]. Despite consistent adherence to the prescribed protocols, the following interventions have failed to yield significant clinical improvement or sustained stabilization.

### 1. Medication Trials:

- **Medication Name:** [Insert Name] | **Duration:** [Dates] | **Outcome:** [e.g., Lack of efficacy / Intolerable side effects]
- **Medication Name:** [Insert Name] | **Duration:** [Dates] | **Outcome:** [e.g., Partial response followed by relapse]

### 2. Therapeutic Interventions:

- **Provider/Facility:** [Insert Name] | **Frequency:** [e.g., Weekly] | **Duration:** [Dates] | **Outcome:** [e.g., Symptoms remained refractory to CBT/DBT]

### 3. Specialized Outpatient Programs (IOP/PHP):

- **Program Name:** [Insert Name] | **Dates:** [Start to End Date] | **Outcome:** [e.g., Patient unable to maintain safety in a community setting]

### Clinical Summary:

The patient continues to experience [List persistent symptoms]. Because the lower levels of outpatient care listed above have proven insufficient, it is my clinical recommendation that the patient be transitioned to [Insert Requested Level of Care, e.g., Residential or Inpatient Treatment] to ensure safety and therapeutic progress.

Please contact my office at [Phone Number] if further documentation is required.

Sincerely,

[Signature]

[Provider Name, Credentials]

[Facility/Practice Name]