

If this is the first OTR for this client complete and return the first page only. This provides a baseline. If this is a second or subsequent OTR, complete both pages. Remember that incomplete OTRs may result in delayed authorizations. Thank You.

**PrimariLink
Outpatient Treatment Report**

Patient Information

Practitioner Information

Name: _____
 Member # _____ DOB: _____
 Date of first session _____ Today's Date: _____

Name/Licensure: _____
 Address: (only if this has changed) _____

 Phone: _____ Fax: _____

DSM-IV Diagnosis (Please complete all 5 Axis)

Axis I: Dx code: _____
 Dx code: _____
 Dx code: _____

Axis IV: circle one: mild moderate severe
 Problems with: (circle)
 primary support, social environment
 occupational /educational, economic, legal.

Axis II: Dx code: _____

Axis V: GAF Scores: initiation of treatment _____
 current ___ highest past yr. _____

Axis III: _____

Risk Assessment: (circle)

Suicidal: None present Ideation Plan Means Prior Attempts Date(s) _____
 Homicidal: None present Ideation Plan Means Prior Attempts Date (s) _____

Medications: (names)

Prescribing MD: _____ Communicated with Practitioner? ___ Date: ___ Client declined: ___

PCP: _____ Communicated with Physician? ___ Date: ___ Client declined: ___

Current Mental Status:

Oriented x _____	Mood:	Affect: Appropriate <input type="checkbox"/> Inappropriate <input type="checkbox"/>	Concentration: Impaired <input type="checkbox"/> Intact <input type="checkbox"/>	Memory: Impaired <input type="checkbox"/> Intact <input type="checkbox"/>
Judgement: Impaired <input type="checkbox"/> Intact <input type="checkbox"/>	Grooming: Appropriate Inappropriate <input type="checkbox"/>	Speech: Normal Rate <input type="checkbox"/> Pressured/ Slow <input type="checkbox"/>	Motivation: Engaged <input type="checkbox"/> Resistant <input type="checkbox"/>	Insight: Impaired <input type="checkbox"/> Intact <input type="checkbox"/>

Presenting Symptoms/Behaviors:

Hallucinations <input type="checkbox"/>	Delusions <input type="checkbox"/>	Loose associations <input type="checkbox"/>	Depersonalization <input type="checkbox"/>	Substance: Use <input type="checkbox"/> Abuse <input type="checkbox"/> Dependence
Ideas of Reference <input type="checkbox"/>	Paranoia <input type="checkbox"/>	Flight of ideas <input type="checkbox"/>	Dissociation <input type="checkbox"/>	
Sleep disturbance <input type="checkbox"/>	Weight changes <input type="checkbox"/>	Depressed mood <input type="checkbox"/>	Expansive Mood <input type="checkbox"/>	Somatizing <input type="checkbox"/>
Irritable <input type="checkbox"/>	Agitated <input type="checkbox"/>	Anxious <input type="checkbox"/>	Panicked <input type="checkbox"/>	Anhedonia <input type="checkbox"/>
Self Injurious <input type="checkbox"/>	Isolated <input type="checkbox"/>	Disorganized <input type="checkbox"/>	Low self esteem <input type="checkbox"/>	Food Restricting <input type="checkbox"/>
Binge/Purging <input type="checkbox"/>	Other: (family, co-occurring issues, self-defeating behaviors, early recovery, etc.)			

From the symptoms above or using clients own words, rate the severity of issues on a scale of 1-7. (1being least severe and 7 most severe). Rate client at the start of treatment and where client currently scores.

Starting Point: Date _____ **Current Rating: Date** _____ **Client Initials:** _____
 (Optional)

1. _____ 1 2 3 4 5 6 7 1 2 3 4 5 6 7

2. _____ 1 2 3 4 5 6 7 1 2 3 4 5 6 7 Provider Initials: _____

3. _____ 1 2 3 4 5 6 7 1 2 3 4 5 6 7

Member name: _____

Clinical Formulation:

1. Using behavioral terms describe the impact of symptoms on daily functioning: (work, friends, family, self defeating behaviors)

2. Describe member's progress or lack of progress:

3. Specify plan for improving functioning:

Treatment Frequency and Duration:

Number of sessions used to date this year: _____ Anticipated Treatment Closure Date: _____

Treatment CPT Code requested: _____ Frequency of sessions: _____

List other services (Medical, Educational, and Community Support) your client is receiving and, if appropriate your contact with them: e.g. AA/NA, group therapy, school counselor, etc.

Active strengths member brings to treatment:

Are there any identified barriers to improvement? If so, please list, i.e., lack of services in the area, poor recovery environment, questionable motivation, lack of family support, etc.:

Is member aware and in agreement with this treatment plan? _____

Signature and comments of Member _____

Signature of Provider _____

Return to below address at least 1 week prior to initiation of additional session request.

PrimariLink
Retreat Healthcare
Anna Marsh Lane
Brattleboro, Vt. 05302

Fax: 802-258-3749
Phone: 800-320-5895
Local: 802-258-6100

Please note that all State and Federal Laws regarding confidentiality of personal health information are strictly adhered to when reviewing, storing, or destroying clinical information.

Revised 11/07: OTR developed with help from more than 100 providers. Thank You.