PrimariLink
Outpatient Treatment Report

Patient Information	Practitioner Information
Name: ________________________ DOB : ____________	Name/Credentials: ______________________________
Member #_____________________	Address:____
	____
	____
Date of first session ___________Today's Date:_________	Phone: _________________Fax: ________________

Incomplete OTRs may result in delayed authorizations

DSM-IV Diagnosis (Please complete all 5 Axis)

Axis I: Dx code:________
Dx code:_______
Dx code:________

Axis II: ______________________ Dx code:_________

Axis III: ____

Axis IV: mild moderate severe
Problems with:
primary support social environment
occupational /educational economic legal

Avis V: initiation of treatment_____
current ____ highest past yr. ______

Previous treatment

Psychiatric
None: ÿ
Inpatient: Outpatient:
Inpatient with in last 12 months: _____
Lifetime # of admissions: ______

Substance Abuse
None
Inpatient Outpatient
Inpatient within last 12 months______
Lifetime # of admissions__________

Risk Assessment:
Suicidality: None present ____ Ideation ÿ Plan ÿ Means ÿ Prior Attempts _____ Date(s) _____________________
Homicidally: None present ____ Ideation ÿ Plan ÿ Means ÿ Prior Attempts_____ Date (s) _____________________
Other:

Medications:

Prescribing Practitioner:______________________________ Have you communicated with this Practitioner ? ______

PCP:____ Have you communicated with PCP? _______

Current Mental Status:

Oriented x______	Mood: " "	Affect: Appropriate ÿ Inappropriate ÿ	Concentration: Impaired ÿ Intact ÿ	Memory: Impaired ÿ Intact ÿ
Judgement: Impaired ÿ Intact ÿ	Grooming: Appropriate Inappropriate ÿ	Speech: Normal Rate ÿ Pressured/ Slow	Motivation: Engaged ÿ Resistant ÿ	Insight: Intact ÿ Impaired ÿ

Presenting Symptoms/Behaviors:

Hallucinations ÿ	Delusions ÿ	Loose associations ÿ	Depersonalization ÿ	
Ideas of Reference ÿ	Paranoia ÿ	Flight of ideas ÿ	Dissociation ÿ	
Sleep disturbance ÿ	Weight changes ÿ	Depressed mood ÿ	Expansive Mood ÿ	Anhedonia ÿ
Irritable ÿ	Agitated ÿ	Anxious ÿ	Panicked ÿ	Somatizing ÿ
Self Injurious ÿ	Isolated ÿ	Disorganized ÿ	Low self esteem ÿ	
Binge/Purging ÿ	Food Restricting ÿ			
Substance: Use ÿ Abuse ÿ	Other:			

Member Name:____

Clinical Formulation

1. Using behavioral terms describe impact of symptoms and behaviors on daily functioning:

2. Describe members progress or lack of progress, and any barriers to treatment:

3. Specify plan for improving functioning:

Treatment Frequency and Duration

Number of sessions used to date ____________ Additional sessions being requested ________.

Treatment CPT code requested _______________ Frequency of sessions: __________________

Other Psychiatric, Medical, or Community Support Services member is involved in. e.g. AA/NA, group therapy

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

Active strengths member brings to treatment:

Signature of Member____
(Optional)

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

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Ph: 800-320-5895
Local: 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.