

**PrimariLink**  
**Outpatient Treatment Report**

**Patient Information**

**Practitioner Information**

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

Name/Credentials: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 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  
**Axis V:** initiation of treatment \_\_\_\_\_  
 current \_\_\_\_ highest past yr. \_\_\_\_\_

**Previous treatment**

**Psychiatric**

None:   
 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  Plan  Means  Prior Attempts \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Homicidally: None present  Ideation  Plan  Means  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 <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	Motivation: Engaged <input type="checkbox"/> Resistant <input type="checkbox"/>	Insight: Intact <input type="checkbox"/> Impaired <input type="checkbox"/>

**Presenting Symptoms/Behaviors:**

Hallucinations <input type="checkbox"/>	Delusions <input type="checkbox"/>	Loose associations <input type="checkbox"/>	Depersonalization <input type="checkbox"/>	
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"/>	Anhedonia <input type="checkbox"/>
Irritable <input type="checkbox"/>	Agitated <input type="checkbox"/>	Anxious <input type="checkbox"/>	Panicked <input type="checkbox"/>	Somatizing <input type="checkbox"/>
Self Injurious <input type="checkbox"/>	Isolated <input type="checkbox"/>	Disorganized <input type="checkbox"/>	Low self esteem <input type="checkbox"/>	
Binge/Purging <input type="checkbox"/>	Food Restricting <input type="checkbox"/>			
Substance: Use <input type="checkbox"/> Abuse <input type="checkbox"/>	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.**