

If this is the first OTR, complete page one only. Subsequent OTR's must have both pages completed.  
 Incomplete OTRs may result in delayed authorizations. Thank You.

**PrimariLink:**  
**Outpatient Treatment Report**  
 Fax Number 802-258-3749

**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: \_\_\_\_\_

Please check: Discussed PCP contact with member: yes \_\_\_\_\_ no \_\_\_\_\_ Contact not appropriate at this time: \_\_\_\_\_

**Current Mental Status:**

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

**Presenting Symptoms/Behaviors:**

Hallucinations	Delusions	Loose associations	Depersonalization	Substance: Use Abuse Dependence
Ideas of Reference	Paranoia	Flight of ideas	Dissociation	
Sleep disturbance	Weight changes	Depressed mood	Expansive Mood	Somatizing
Irritable	Agitated	Anxious	Panicked	Anhedonia
Self Injurious	Isolated	Disorganized	Low self esteem	Food Restricting
Binge/Purging				
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. (1 being least severe and 7 most severe). Rate client at the start of treatment and where client currently scores.

<b>Starting Point: Date</b> _____	<b>Current Rating: Date</b> _____	<b>Client Initials:</b> _____ (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	<b>Provider Initials:</b> _____
3. _____ 1 2 3 4 5 6 7	1 2 3 4 5 6 7	

Member name: \_\_\_\_\_

If this is a subsequent OTR, we ask that you & the member take a moment to review the course of care to make sure you agree on goals, interventions, & progress. Completing this second page will provide more information on progress & identify possible changes you and the member may take.

**Summarize Progress & areas that remain in need of care:**

**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 other 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  
P.O. Box 803  
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 8/08: OTR developed with help from more than 100 providers. Thank You.**