

**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

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

Practitioner Information

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 II: Dx code: _____

Axis III: _____

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

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

Risk Assessment: (circle)

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

Required: Medications: (names)

Psychiatric Prescriber: _____ Date of last communication w/ prescriber: _____

PCP: _____ Date of last communication w/ PCP: _____

Date PCP contact discussed with member: _____ Member Agreed to contact _____ Member declined contact: _____

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"/>	Somatizing <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"/>	Panic <input type="checkbox"/>	Food Restricting <input type="checkbox"/>
Self Injurious <input type="checkbox"/>	Isolated <input type="checkbox"/>	Disorganized <input type="checkbox"/>		
Binge/Purging <input type="checkbox"/>				
Other: (family, co-occurring issues, self-defeating behaviors, early recovery, etc.)				

From the symptoms listed above; have client rate the severity of issues on a scale of 1-7 (1 least severe/7 most severe). If you disagree with assessment note your score as well. **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: _____

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 6/30/10: OTR developed with help from more than 100 providers. Thank You.