



# Outpatient Mental Health Treatment Report

All fields must be completed and legible or the request cannot be processed

Client Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Date of first visit: \_\_\_\_\_ Primary Therapist \_\_\_\_\_

Member # \_\_\_\_\_ Agency/Clinic \_\_\_\_\_

Diagnosis/DSMIV Codes: Axis I \_\_\_\_\_ Axis II \_\_\_\_\_ Axis III \_\_\_\_\_

### Current Symptoms (check all that apply)

- |                                                       |                                                   |                                                 |                                                    |
|-------------------------------------------------------|---------------------------------------------------|-------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Disoriented                  | <input type="checkbox"/> SI/HI/Self Injurious     | <input type="checkbox"/> Sleep Disturbance      | <input type="checkbox"/> Oppositional Defiant      |
| <input type="checkbox"/> Memory                       | <input type="checkbox"/> Emotional Dysregulation  | <input type="checkbox"/> Anxious                | <input type="checkbox"/> Decreased Impulse Control |
| <input type="checkbox"/> Hallucinations               | <input type="checkbox"/> Depressed/Expansive Mood | <input type="checkbox"/> Panic Attacks          | <input type="checkbox"/> Irritability              |
| <input type="checkbox"/> Paranoid                     | <input type="checkbox"/> Psychomotor retardation  | <input type="checkbox"/> Phobic                 | <input type="checkbox"/> Agitation                 |
| <input type="checkbox"/> Delusions                    | <input type="checkbox"/> Anhedonia                | <input type="checkbox"/> Flashbacks             | <input type="checkbox"/> Food restriction          |
| <input type="checkbox"/> Disorganized                 | <input type="checkbox"/> Isolation                | <input type="checkbox"/> Dissociation           | <input type="checkbox"/> Binge/Purging             |
| <input type="checkbox"/> Ideas of Reference           | <input type="checkbox"/> Grief                    | <input type="checkbox"/> Obsessions/Compulsions | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Loose Assoc. Flight of Ideas | <input type="checkbox"/> Social Withdrawal        | <input type="checkbox"/> Decreased Energy       | _____                                              |

### Current Functional Impairment (please rate): 0=None 1=Mild 2=Moderate 3=Marked 4=Extreme

\_\_\_\_\_ Ability to concentrate      \_\_\_\_\_ Eating Habits      \_\_\_\_\_ Relationships  
 \_\_\_\_\_ Activities of Daily Living      \_\_\_\_\_ Financial Situation      \_\_\_\_\_ School/Employment

Current Substance Abuse/Alcohol Abuse?  Y  N      Current SA/Alcohol Tx?  Y  N      Past SA/Alcohol Tx?  Y  N

Have you communicated with the primary care physician?  Y  N

Is member in treatment with another behavioral health practitioner?  Y  N      Have you communicated with them?  Y  N

Within the last 12 months was the member hospitalized for a MH or SA/alcohol diagnosis?  Y  N

Medications: Name/Dosage/Frequency: \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Is compliance noted? \_\_\_\_\_

Have you spoken with the psychiatric prescriber?  Y  N

1. Have any of the member's targeted treatment goals been achieved to date? If so, what? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

2. What measureable goals remain? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

3. Please identify any barriers to successful treatment \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

4. Please specify a clear plan of action for goal attainment and a reasonable timeframe \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Anticipated frequency of visits \_\_\_\_\_ Anticipated end date \_\_\_\_\_

Modality:  Individual  Family  Other  Group (type) \_\_\_\_\_

Provider Name and credentials \_\_\_\_\_ Provider Signature: \_\_\_\_\_

Provider Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Date: \_\_\_\_\_

Send to: Behavioral Health Services, c/o CDPHP, 500 Patroon Creek Blvd., Albany, NY 12206-1057 or fax to (518) 641-3601.  
 Approval of this OTR does not guarantee payment of benefits. Final determination is based on eligibility, deductibles and plan limits.