



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 _____ # of sessions used to date _____

Modality: Individual Family Other Group (type) _____

Provider Name/Credentials: _____ NPI #: _____ 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.

