

# OUTPATIENT TREATMENT REPORT

PATIENT Name: \_\_\_\_\_

ID # \_\_\_\_\_ DOB: \_\_\_\_\_

**PROVIDER:**

\_\_\_\_\_  
Individual and/or Group

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**COORDINATION of CARE:**

☎ I have communicated with patient's PCP or specialist:  Yes  No  N/A

☎ I have communicated with patient's psychiatrist or therapist:  Yes  No  N/A

**ICD-9\* DIAGNOSIS** numeric + description (\*DSM-IV codes typically correspond to ICD-9 codes) :

Axis I

Axis II

Axis III

Axis IV

Axis V (current) \_\_\_\_\_ (highest past year)

**PSYCHOTROPIC MEDICATIONS:** Prescribed by:  PCP  Psychiatrist  APRN

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

If affective or psychotic disorder is present and no medications are prescribed, please explain:

**RISK ASSESSMENT:**

Suicidal:  Ideation  Planned  Imminent Intent  History of self-harming behavior

Homicidal:  Ideation  Planned  Imminent Intent  History of behavior harming others

**TREATMENT HISTORY** (all prior behavioral treatment) :

Inpatient:  Within past year  1 to 3 yrs ago  More than 3 years ago

Outpatient:  Within past year  1 to 3 yrs ago  More than 3 years ago

**SYMPTOMS - if present, check degree (✓)**

	Mild	Mod.	Severe		Mild	Mod.	Severe
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Mood Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions/Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**FUNCTIONAL IMPAIRMENT**

ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family/Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance of Abuse:	<input type="checkbox"/> ETOH	<input type="checkbox"/> Rx Drug	<input type="checkbox"/> Other: _____

**DEFINITION OF SUCCESSFUL TREATMENT**

Desired observable outcomes #1.

Desired observable outcomes #2

**LEVEL of IMPROVEMENT to DATE:** # Sessions provided to date: \_\_\_\_\_

Minor  Moderate  Major  No progress to date  Maintenance tx of chronic condition

Start date for new auth \_\_\_\_\_

**PROVIDER'S CONTINUED TREATMENT PLAN (requested services):**

MODALITIES	FREQUENCY	ANTICIPATED COMPLETION
<input type="checkbox"/> Individual	<input type="checkbox"/> weekly	<input type="checkbox"/> less than 1 month
<input type="checkbox"/> Family/Couple	<input type="checkbox"/> twice per month	<input type="checkbox"/> 1 to 2 months
<input type="checkbox"/> Group	<input type="checkbox"/> monthly	<input type="checkbox"/> 2 to 4 months
<input type="checkbox"/> Medication Management	<input type="checkbox"/> less than monthly	<input type="checkbox"/> more than 4 months

\_\_\_\_\_  
**Provider Signature**

My signature confirms that I am providing the requested services

\_\_\_\_\_  
**Date**