



OUTPATIENT TREATMENT PLAN

Grid of 10 empty boxes

Patient Information:

Name (first):
Address (street):
(City, State, Zip):
Date of Birth:
Sponsor SSN:

Provider Information: (needed on each OTP)

Name (Last, First):
Address (street):
(City, State, Zip):
Telephone Number:
Fax Number:
Date of Birth:
SSN:

Patient Primary Care Manager (PCM) Information:

Name (Last, First):
Telephone Number:
Fax Number:

Clinical Information:

- Date of the patient's first session:
Date of the patient's most recent session:
Number of sessions the patient has had to date:

Description of why the patient sought treatment at this time: (include existing psychosocial, family history, environmental, educational, occupational, and developmental functioning)\*

Is there a history of prior mental health/substance abuse treatment? Yes No (If yes, please provide a chronological psychiatric, medical, and substance use history with time frames and outcome, if available.)\*

Mental Status to validate DSM-IV diagnosis (affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control).

Current DSM-IV diagnosis (all five axes):

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V: GAF Highest in the past year At the first session Current

\*Answer completely on initial OTP only. On subsequent OTPs, note only changes or new information.

Patient's First Name: \_\_\_\_\_

Sponsor SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Currently taking psychotropic medications:  Yes  No (if yes, please note the medications below)

Medication	Dose	Frequency	Lab Results (if any)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Target symptoms, goal with target date, and patient's response to date (new goal, improved, unchanged, regressed, completed)

Symptom	Goal	Target Date Month/Year	Patient's Response
1. _____	_____	____/____	_____
2. _____	_____	____/____	_____
3. _____	_____	____/____	_____
4. _____	_____	____/____	_____

Treatment modalities utilized, frequency of sessions, number of sessions required for completion of this outpatient treatment episode.

Modality	Frequency of Sessions	Estimated Number to Completion	Name of Provider
1. Individual therapy	_____	_____	_____
2. Family therapy	_____	_____	_____
3. Group therapy	_____	_____	_____
4. Medication Management	_____	_____	_____

Are there potential barriers to the patient's ability to make progress?  Yes  No If yes, please specify.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If there are other providers involved in this episode of treatment, is there coordination of all services being rendered?

Yes  No If yes, who is the coordinator? \_\_\_\_\_

Estimated date of completion for this episode of care: \_\_\_\_/\_\_\_\_/\_\_\_\_

_____	_____	____/____/____
Provider's Name (printed)	Provider's Signature with Credentials	Date

_____	_____	____/____/____
APS Reviewer's Signature	# Sessions Authorized	Review Date

Fax or mail this completed form to:

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