Mental Health Network, Inc.

OUTPATIENT TREATMENT RECORD – OTR

Please fax to (504) 833-2107 or mail to MHNet; Lakeway III; 3838 N. Causeway Blvd., Suite 2250; Metairie, LA 70002

Member Name: _____ DOB: ___/___/___ Age: ___ Gender: M/F ID# _____

Insurance: _____

Effective Date: ___/___/___ Practitioner: _____ Licensure: _____ Phone: ( ) _____

Fax: ( ) _____ Address: _____ City, State, Zip: _____

Authorization #: _____ PCP: _____ Phone/Fax: ( ) _____

Member Agreement and Consent to Release Information: I have read and agree with the treatment. I consent to the release of my outpatient treatment reports to my PCP and any other behavioral health practitioner from which I am receiving care authorized by MHNet. This information will be shared with them to monitor my care and to inform them of any medication changes if applicable.

☐ *Agree* ☐ *Decline*

Member or Legal Guardian's Signature: _____ Date Signed: ___/___/___ (Expires in 12 months)

Note to Recipient: This confidential information has been disclosed to you from records that may be protected by Federal law and regulation found at 42 USC 290dd-2 and 42 CFR Part 2, dealing with confidentiality of alcohol and drug abuse patient records, as well as State law dealing with mental illness. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. State law may require the same. It is provided to you as the primary care physician or behavioral health practitioner for the above named Client solely for continuity of care purposes and to inform you of your patient's health status. Violation of this Federal law or regulation is a crime and suspected violations may be reported to appropriate authorities in accordance with Federal regulation. Federal law and regulations do not protect any information about a crime committed by a patient or information about any threat to commit a crime, nor do they protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

CLINICAL INFORMATION BASED ON MOST RECENT ASSESSMENT

(Please check all items that apply)

CURRENT RISK FACTORS

Impairment In Safety:
- ☐ Thoughts, with plan to harm self/others
- ☐ Means and plan to harm self or others
- ☐ Prior attempts to harm self or others
- ☐ Disposing of possessions
- ☐ Social isolation
- ☐ Recent loss or failure
- ☐ Family history of suicide
- ☐ Suicide by friend or associate
- ☐ Strong urge to get even/rageful affect
- ☐ Assault episodes or domestic violence
- ☐ Facing criminal charges

Impairments in Reality Construction:
- ☐ Hallucinations
- ☐ Bizarre behavior
- ☐ Thought disturbance
- ☐ Delusions
- ☐ Paranoia
- ☐ Disorientation or dissociation
- ☐ Confusion, inattention, or memory loss

Affective Features:
- ☐ Significant weight changes
- ☐ Appetite changes
- ☐ Sleep disturbance
- ☐ Decreased libido &/or sexual activity
- ☐ Anhedonia

Impairments in Self Care and/or Social Functioning:
- ☐ Cannot meet basic ADL's
- ☐ Impaired social functioning
- ☐ Behavior that violates rights of others; Self-damaging impulsivity

Complicating Conditions:
- ☐ Multiple psychotropic medications
- ☐ Medical complications, chronic illness
- ☐ Parental neglect or abuse
- ☐ Anorexia symptoms
- ☐ Bulimia symptoms
- ☐ Anxiety symptoms
- ☐ Panic symptoms
- ☐ Unstable family supports

Substance Abuse Factors:
- ☐ Excessive alcohol consumption
- ☐ Illicit drug use
- ☐ History of alcohol or drug abuse
- ☐ Tolerance or cross tolerance
- ☐ Withdrawal syndrome
- ☐ History of DTs &/or blackouts
- ☐ Rarely, if ever, abstinent
- ☐ Legal problems for substance abuse
- ☐ History of seizures
- ☐ Head trauma

Prior MH/CD Hospitalizations:
- ☐ Multiple admissions (#_____)
- ☐ Most recent discharge _____
- ☐ No prior hospitalizations

Immediate Stressors: _____

DSM-IV Diagnostic Impressions:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF_____ Past Year_____

Allergies: _____

Psychotropic Medication: _____

Degree of Risk Factor Impairment on Current Functioning:

Ability to Care for Self:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Ability to Function at Work/School:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Ability to Cope with Unexpected Change:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Ability to Form/Keep Positive Relationship:	☐ None	☐ Mild	☐ Moderate	☐ Severe

Progress Towards Goals Since Last Review:

Ability to keep self/ others from harm:	☐ Improved	☐ Unchanged	☐ Regressed	☐ Goal Completed
Ability to care for self:	☐ Improved	☐ Unchanged	☐ Regressed	☐ Goal Completed
Appropriate Mood/Thoughts	☐ Improved	☐ Unchanged	☐ Regressed	☐ Goal Completed
Ability to act age appropriate:	☐ Improved	☐ Unchanged	☐ Regressed	☐ Goal Completed
Ability to Adapt to Change:	☐ Improved	☐ Unchanged	☐ Regressed	☐ Goal Completed

Disposition:

Refer for medication evaluation	○ Yes	○ No
Refer for therapy/counseling	○ Yes	○ No
<18; Family therapy planned	○ Yes	○ No

If No, why? _____

Initial Evaluation Date: _____

Expected Discharge Date: _____

Sessions Completed: _____

Frequency of Visits: _____ per_____

Requested CPT Code: _____

_____

Practitioner signature and date