OPTUM**

Outpatient Treatment Report

Please answer each question and fax to (866) 822-1739 or mail to 205 East Water Tower Lane, Meridian, ID 83642.

If you have submitted a current Wellness Assessment for this client you do not need to complete/submit this form.

Client Name | Date of Birth | Subscriber ID

Practitioner Name | Practitioner State | Authorization #

Please complete the required information:

Practitioner ID/Tax ID ☐☐☐☐☐☐☐☐☐☐ Practitioner Phone ☐☐☐ ☐☐☐-☐☐☐☐ Requested Start Date for this Authorization ☐☐/☐☐/☐☐

1. Disorder(s) Being Treated (Axes I & II): ☐☐☐.☐☐ ☐☐☐.☐☐ ☐☐☐.☐☐

Axis III:

☐ None ☐ Asthma/Pulmonary Disease ☐ Chronic Pain
☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Other

2. How long ago did the patient first experience symptoms related to the primary diagnosis?
   ☐ < 6 Months ☐ 7-12 Months ☐ 13-24 Months ☐ > 24 Months
3. History of Psychiatric Hospitalization
   How many times has the patient been hospitalized for a psychiatric condition?
   ☐ None ☐ 1 ☐ 2 ☐ 3+
   If the patient was hospitalized within the past 12 months, how long ago was the patient's most recent hospitalization?
   ☐ 0-3 Months ☐ 4-6 Months ☐ 7-12 Months ☐ n/a
   What was the duration of the most recent hospitalization?
   ☐ 1-2 Days ☐ 3-5 Days ☐ 6-10 Days ☐ > 10 Days
4. Symptoms/Functional Impairment

	None	Mild	Moderate	Severe
Depression	☐	☐	☐	☐
Mania	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐
Cognitive Impairment	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Aggressive Behavior	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐
Substance Abuse/Dependence	☐	☐	☐	☐
Work/School	☐	☐	☐	☐
Relationship/Family	☐	☐	☐	☐

5. Is compliance with medication treatment a problem?
   ☐ Yes ☐ No ☐ Don't Know
6. Is the patient currently receiving or in need of substance abuse treatment?
   ☐ Outpatient ☐ Inpatient ☐ None
7. Has the patient received a referral for a medication evaluation? (Check "Yes" if a referral has been given by you or you are the prescribing practitioner)
   ☐ Yes ☐ No ☐ None
8. Has the patient received a prescription for psychotropic medication(s)?
   ☐ No -- Skip questions 9-11
   ☐ Yes -- ☐ Antidepressant ☐ Anti-anxiety ☐ Antipsychotic ☐ Mood Stabilizer ☐ Stimulant ☐ Sedative/Hypnotic ☐ Anticonvulsant
9. Who is prescribing these medications?
   ☐ I am the Prescribing Practitioner ☐ Psychiatrist ☐ Other Medical Practitioner
10. If you are not the prescribing practitioner, have you initiated contact with the prescribing practitioner?
    ☐ Yes ☐ No ☐ No, but contact planned
11. If applicable, is the patient compliant with the prescribed psychotropic medication(s)?
    ☐ Yes ☐ No

12. Progress Update ☐ Initial Assessment If already in treatment:
    ☐ Compliant, Progressing and Improving – Needs more treatment
    ☐ Compliant, Progressing and Improving – Plan for discharge
    When?____/____/____
    ☐ Compliant, Not progressing nor Improving
    ☐ Not Compliant, Not Progressing nor Improving
13. Mode of treatment (check all that apply): ☐ Individual Psychotherapy ☐ Group Therapy ☐ Medication ☐ Other
14. Number of sessions anticipated to complete treatment.
    ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10
15. Expected Outcome and Prognosis
    ☐ Return to normal functioning
    ☐ Expect improvement, anticipate less than normal functioning
    ☐ Relieve acute symptoms, return to baseline functioning
    ☐ Maintain current status/prevent deterioration
16. Frequency of Sessions ☐ Less than once a week ☐ Once a week ☐ Greater than once a week
17. Number of sessions to date in this treatment episode
    ☐ <10 ☐ 11-16 ☐ 17-22 ☐ >22

Signature: | Date

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