APS Healthcare

OUTPATIENT TREATMENT PLAN

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:

APS Military Healthcare Services, LLC
TRICARE Puerto Rico
Humana Military Healthcare Services
PO Box 195519
San Juan, Puerto Rico 00919
Fax: 800-788-1366 – Phone: 800-700-7104