SELECT ONE:
Initial Registration ☐
Continued Stay Review ☐

Project SAFE Outpatient Treatment Review Form (OTR)

Client Name (Last, First): ______________________
ABH Number: ____________
Client's Date of Birth: __________ Admission Date: __________
Client's Address: ______________________
Provider Name: ______________________
Provider Service Address: ______________________

Service Type (MUST select one):
☐ SA Partial Hospital (SA II.5)
☐ MH Partial Hospital (MH II.5)
☐ SA Intensive Outpatient (SA II.1)
☐ MH Intensive Outpatient (MH II.1)

DIAGNOSES – (Required) *Substance Abuse diagnosis must be primary*
____
____
____
____
____
____

Treatment Plan: ______________________
____
____
____
____

Expected Frequency & Duration of IOP ________ x per week for ________ weeks

Expected Frequency & Duration of PHP ________ x per week for ________ weeks

Requested Number of Units (Required): ________

Projected Discharge Plan (Required):
Anticipated Discharge Date: ______________
Referral Projected to: ______________________ (Service/Level of Care)
______________________ (Provider Name)

Substance Use History (Required for all OTRs):

Substance	Date Last Used	Method of Use	Age at First Use	Quantity	Frequency

Current Medications: ☐ No Medications

Medication	Dosage	Frequency	Method	Ended On

Status Checklist
☐ Medication Compliant
☐ Medication Non-compliant
☐ Significant Risk for Relapse
☐ Vocational/Job Issues
☐ Housing Issues
☐ Current/Chronic Medical Issues
☐ Pending/Current Legal Issues
☐ Attending 12-Step Recovery Groups
☐ Using Community Supports
☐ Frequent Therapeutic Intervention Needed
☐ Frequently Misses Appointments
☐ Compliant with Treatment
☐ Refusing Treatment Recommendations
☐ Stable/Preparing for Discharge
☐ In Need of Higher Service Intensity
☐ Progress Made/Further Stabilization Needed
☐ No Progress Made/Improvement Expected
☐ Lacks Necessary Community Supports

Date/Results of Drug Toxicology (Required for all OTRs):
Date of Most Recent Drug Toxicology: __________ ☐ Never tested
Results: ☐ Positive ☐ Negative
If Positive, MUST select at least one:
☐ Opiates ☐ Benzodiazepines
☐ Cannabis ☐ Cocaine

Symptom Checklist (Select at least one – Required)
☐ Isolation
☐ Eat/Sleep Disturbance
☐ Manic Behavior
☐ Inadequate Self Care
☐ Recent Relapse
☐ Current symptoms of withdrawal
☐ Delusions/Hallucinations
☐ Peer/Relationship Difficulty
☐ Suicidal/Homicidal Ideation
☐ Sexually Inappropriate Behavior
☐ Active Substance Abuse
☐ Paranoia
☐ Bizarre Behavior
☐ Violent/Aggressive Behavior
☐ Attention/Impulse Disorder
☐ Confusion/Disorientation
☐ Early Recovery Issues
☐ Obsessive/Compulsive Behaviors
☐ Depression
☐ Nightmares/Flashbacks
☐ Anxiety/Panic Attacks
☐ Recent suicide attempt(s)
☐ Intense/Frequent Drug Cravings
☐ Cognitive Impairment
☐ Substance-related Medical Issues
☐ Acute psychosocial stressors
☐ Thought Disorder
☐ Inappropriate Affect

Form Completed By: ______________________ **Telephone #:** __________ **Date:** __________

Reviews may be faxed to: Advanced Behavioral Health, Inc. at (860) 638-5302
Please keep a record of this transaction for your records

Updated 3/23/16