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
☐ MH Partial Hospital (MH II.5
☐ MH Intensive Outpatient (MH II.1)
☐ SA Day/Evening Treatment (SA II.5)
☐ SA Intensive Outpatient (SA II.1)

DIAGNOSES – AXIS I – V (Required)
Axis I: (1)_____ (2)_____ (3)_____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: Current GAF: _____Highest GAF/Past Yr: _____ Lowest GAF/Past Yr: _____
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 OTR's):

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 OTR's):
☐ Never Tested
Date of Most Recent Drug Toxicology: _____
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