



-----Member Name

Has a psychiatric evaluation been completed?  Yes \_\_\_\_\_(date)  No / If no, indicate why this has not been completed.

**SUBSTANCE USE DISORDER**

None  By History  Current/Active Use

DRUG	AMOUNT	FREQUENCY	FIRST USE (DATE)	LAST USE (DATE)

Is member attending AA/NA meetings?  Yes  No If yes, how often? \_\_\_\_\_

Current step \_\_\_\_\_ Was a sponsor identified?  Yes  No

**RELAPSE HISTORY**

Date of last relapse \_\_\_\_\_  
Drug and amount used \_\_\_\_\_  
Resulting consequences \_\_\_\_\_  
\_\_\_\_\_

**TREATMENT DETAILS**

What therapeutic approach (e.g. evidence-based practice, therapeutic model, etc.) is being utilized with this member?

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Member's current level of motivation?  None  Minimal  Moderate  High

Are the member's family/supports involved in treatment?  Yes  No If no, why? \_\_\_\_\_

Date of last family therapy session and progress made? \_\_\_\_\_

What other services are being provided to this member that are not requested in this OTR? Please include frequency \_\_\_\_\_

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Is care being coordinated with member's other service providers?  Yes  No  N/A

Has information been shared with PCP regarding behavioral health provider contact information, presenting problem, date of initial visit, diagnoses and any meds prescribed?  Yes \_\_\_\_\_ (date)  No If no, why? \_\_\_\_\_

**TREATMENT GOALS**

Describe measurable goals and treatment plan agreed upon by member.

MEASURABLE GOAL	DATE INITIATED	CURRENT PROGRESS (PLEASE NOTE SPECIFIC PROGRESS MADE.)

