# Methadone Treatment Report

**IF NOT LEGIBLE AND COMPLETE, OTR WILL BE RETURNED**
**Providers are no longer being asked to designate a certain number of requested sessions**. Per MVP protocol, the information contained in this document will be utilized by the Behavioral Health Case Manager/Medical Director to determine medical necessity and the number of additional sessions certified. If additional sessions are still needed, when the member is close to utilizing the number of the assigned sessions, an updated OTR may be submitted for further consideration.

Member Name

MVP ID # DOB PCP

SA Provider/Agency MVP Provider ID#

Date Began Methadone:

Diagnosis: Axis I: Axis II:

Physiological Dependency Upon Opiate Drug: ☐ Yes ☐ No

Drugs of Choice:

Date of onset opiate addiction: Date of last use of opiates:

Stage of Treatment: ☐ Initial ☐ Early Stabilization ☐ Middle ☐ Long term ☐ Medically Supervised Withdrawal

What brought the member into treatment and why Methadone
instead of abstinence-based recovery program?

Medical Issues:

Medications: Name/Dosage/Frequency (including methadone or buprenorphine). Is the member compliant with psychotropic medications

☐ Yes ☐ No (If Applicable):

**Prior Treatment:** (Mark box: If multiple admissions write # of times in box)

First time in treatment ☐ Detoxification ☐ Rehabilitation ☐ Day Treatment/PHP ☐

Outpatient ☐ IOP ☐ Residential at Treatment ☐ Halfway House ☐

Is member abstinent from alcohol or other addictive drugs? ☐ Yes ☐ No
If no, describe:

**CURRENT FUNCTIONAL IMPAIRMENT (AS OF THE OTR COMPLETION DATE): (CIRCLE LEVEL)**

| **Categories** | **No Impairment** | **Mild Impairment** | **Moderate Impairment** | **Marked Impairment** | **Extreme Impairment** |
|---|---|---|---|---|---|
| Marriage/Family | 1 | 2 | 3 | 4 | 5 |
| Job/school/Performance | 1 | 2 | 3 | 4 | 5 |
| Friendship/Peer Relations | 1 | 2 | 3 | 4 | 5 |
| Financial Situation | 1 | 2 | 3 | 4 | 5 |
| Legal | 1 | 2 | 3 | 4 | 5 |
| Personal hygiene, grooming etc. | 1 | 2 | 3 | 4 | 5 |
| Health/Nutrition | 1 | 2 | 3 | 4 | 5 |
| Sleeping Habits | 1 | 2 | 3 | 4 | 5 |
| Housing | 1 | 2 | 3 | 4 | 5 |

**Urine Drug Screens:**

Frequency Dates and Outcome

**External Support Involvement:**

☐ None Reported/Unknown

☐ AA/NA: Self Reported Meetings per week____________ If not, why?_______________________________________________________

☐ Other external supports used:___________________________________________________________________________

**Readiness to change: Mark the box next to the statement that applies (as of OTR completion date):**

The member was willing to enter treatment to explore strategies for changing, but is still ambivalent about the need to change ☐

The member has been reluctant to enter treatment and continues to have a low commitment to change ☐

The member exhibits inconsistent follow through and shows minimal awareness of his or her need for treatment ☐

**Relapse/Continued Use Potential: mark the box next to the statement that applies (as of OTR completion date):**

The member has no potential for further substance use and has good coping skills ☐

The member has minimal relapse potential with some vulnerability and has learned relapse prevention skills ☐

The member has impaired understanding of substance use issues and should continue in a relapse prevention program ☐

The member has little understanding of substance use issues and has poor skills to avoid or limit continued use ☐

**Recovery Environment: Mark the box next to the statement that applies (as of OTR completion date):**

The member has a supportive environment or is able to cope with limited supports ☐

The member has a passive supportive environment but is not distracted and is able to cope ☐

The member's environment is not supportive of addiction recovery, but with clinical structure is able to cope ☐

The member's environment is not supportive of addiction recovery, and finds coping difficult, even with clinical structure ☐

**Summarize member's treatment and progress.**
If there is a lack of progress describe what modifications have been made in treatment to facilitate a better outcome:

Services were provided to family members: ☐ Yes ☐ No

Has the member participated in the development of the treatment plan? ☐ Yes ☐ No

Have you communicated with the Primary Care Physician? ☐ Yes ☐ No

Is member currently in treatment with another behavioral health practitioner? ☐ Yes ☐ No

Practitioner Name:

Have you communicated with him/her? ☐ Yes ☐ No

Clinical Reasons for additional sessions:

Total # of sessions attended: Medication Only: Individual Group IOP

Treatment Modality: Medication Only: Individual Group IOP

Frequency of visits: Daily Bi-Weekly Weekly Bi-monthly Monthly

Frequency of medication pick-up: Daily Bi-Weekly Weekly Bi-monthly Monthly

Provider Name (Print) Credential:

Signature: Date:

Telephone and extension: Fax Number:

***Outpatient Treatment reports for Vermont members should be sent to PrimariLink. The fax number is 802-258-3749. Please call PrimariLink at 1-800-320-5895 with any questions**.