Office of
Victim Services

**ANDREW M. CUOMO**
Governor

**ELIZABETH CRONIN ESQ.**
Director

# MENTAL HEALTH TREATMENT REPORT – OUTPATIENT

DATE OF REPORT: _____

**PATIENT INFORMATION**

NAME: _____ CLAIM NO.: _____

ADDRESS: _____

_____ DATE OF BIRTH:

_____ SEX: ____ MALE ____ FEMALE

TELEPHONE: ( ) _____

DATE OF CRIME: _____ MARITAL STATUS: _____

DATE TREATMENT BEGAN: / / CONTINUING: ____ YES ____ NO TERMINATED: / /

DIAGNOSIS (USE D.S.M. IV)

1. 4.
2. 5.
3. 6.

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**I** **PLEASE RESPOND TO ALL ITEMS – USE ADDITIONAL PAGES IF NECESSARY**

1. State the claimant/victim's initial reasons for seeking treatment. Describe how and when the condition was first manifested. Summarize previous treatment efforts, if any.

2. Please describe, in detail, the relationship between the crime and the need for treatment.

3. Does the claimant/victim have a history of a pre-existing psychiatric disorder? Yes No
   If yes, please describe that disorder, reasons(s) for treatment, type(s) of treatment and date(s).

4. What percent of the current mental health treatment is causally-related to the date of crime for which this claim is based? Check the percentage that applies or indicate another percentage. **This must be completed**.
   ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100% Other: _____

5. In your opinion, would the claimant/victim be in treatment if it weren't for the crime?

6. Describe the claimant/victim's current condition. Include the duration and severity of functional impairments and stress factors and the period of disability from employment.

   Date disability began: / /

   Date disability ended: / /

7. Please describe current causally-related treatment goals and estimated duration of treatment to achieve stated goals.

## II COMPONENTS OF TREATMENT PLAN

1. Psychotherapy: Specify types, frequency and length of sessions (if group therapy, also give number of patients in group).

2. Medication: Please list only causally-related medications that are needed as a direct result of the crime.

3. Adjunctive therapies: (e.g. physical or occupational therapy). Specify type, frequency and duration.

4. If psychotherapy sessions are more than two (2) per week provide rationale.

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**III** Other remarks or additional detail that would assist professional reviewer in understanding this claim.

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**IV** Prognosis:

SIGNATURE OF PROVIDER _____ DATE _____

## PROVIDER INFORMATION

NAME: _____ LICENSE #: _____

ADDRESS: _____ AGENCY: _____

_____ SOCIAL SECURITY #: _____

TELEPHONE #: ( ) _____