VALUEOPTIONS OUTPATIENT REGISTRATION FORM (ORF 1)

Please complete all sections for submission to ValueOptions. TYPE or PRINT LEGIBLY. Check/circle response where applicable.

Member and Provider Demographics:

Member's Name: _____

Date of Birth: _____ Member's Age: ____ Gender: ❑M ❑F

Member's Address (City/State only): _____

Member's ID # _____

Insured's Employer/Benefit Plan: _____

Is member currently receiving disability benefits? ❑Yes ❑No ❑Unknown

Provider Name: _____

Provider Program/Clinic (if applicable): _____

VO Provider # (if known): _____

Service Address: _____

City/State/Zip _____

Provider Telephone#: _____

Are you independently licensed? ❑Yes ❑No

Licensure level (type of license): _____

State which issued this license: _____

Provider SSN or Tax ID #: _____

DSM-IV Diagnosis and Risk Assessment:

Please circle type of service requested: Mental Health Substance Abuse

Please indicate primary diagnosis:

Axis I: _____ Axis II: _____

Current Risk Assessment:

Scale: 0=none 1=mild, ideation only

2=moderate, ideation with EITHER plan or history of attempts

3=severe, ideation AND plan, with either intent or means

na=not assessed

(Please select/circle one value for each type of risk)

Member's risk to self:	0	1	2	3	na
Member's risk to others:	0	1	2	3	na

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Medical Conditions (Axis III):

Please circle Member's medical conditions:

None/Other	Asthma	Chronic pain	Cancer
Cardiovascular problems	Diabetes	Pulmonary disease	

Current Impairments: *(please select/circle one value for each type of impairment)*

Scale: 0=none 1=mild/mildly incapacitating 2=moderate/moderately incapacitating

3= severe or severely incapacitating na = not assessed

Mood Disturbances (Depression or Mania)	0	1	2	3	na
Anxiety	0	1	2	3	na
Psychosis/Hallucinations/Delusions	0	1	2	3	na
Thinking/Cognition/Memory/Concentration Problems	0	1	2	3	na
Impulsive/Reckless/Aggressive Behavior	0	1	2	3	na
Activities of Daily Living Problems	0	1	2	3	na
Weight Loss Associated with Eating Disorder	0	1	2	3	na
Medical/Physical Condition	0	1	2	3	na
Substance Abuse/Dependence	0	1	2	3	na
Job/School Performance Problems	0	1	2	3	na
Social/Relationships/Marital/Family Problems	0	1	2	3	na
Legal Problems	0	1	2	3	na

Requested Services:

Requested Start Date for this registration: _____

Please indicate type(s) of service provided and frequency.

❑Medication Management 90862 ❑Wkly ❑Mnthly ❑Qtrly ❑Other _____

❑Indiv. Psychotherapy (20-30 min) 90804 ❑Wkly ❑Mnthly ❑Qtrly ❑Other _____

❑Indiv. Psychotherapy (45-50 min) 90806 ❑Wkly ❑Mnthly ❑Qtrly ❑Other _____

❑Family Psychotherapy (45-50 min) 90847 ❑Wkly ❑Mnthly ❑Qtrly ❑Other _____

❑Group Therapy (60-90 min) 90853 ❑Wkly ❑Mnthly ❑Qtrly ❑Other _____

❑Other _____ ❑Wkly ❑Mnthly ❑Qtrly ❑Other _____

❑Other _____ ❑Wkly ❑Mnthly ❑Qtrly ❑Other _____

Treating Provider's Signature: _____

Date: _____