VALUEOPTIONS OUTPATIENT REVIEW FORM (ORF 2)

START HERE⇨ **Requested Start Date for this registration:** _____

Select Type of Service Requested: ❑ Mental Health ❑ Substance Abuse

Provider and Member Demographics:

Member's Name: _____

Date of Birth: _____ Member's ID # _____

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

Insured's Employer/Benefit Plan: _____

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

Provider Name: _____

VO Provider # (if known): _____

Service Address: _____

Provider Telephone#: _____

Provider SSN or Tax ID #: _____

Current Risks:

(please select one rating for each type of risk. Key: 0= none; 1= mild, ideation only; 2= moderate, ideation with EITHER plan or history of attempts; 3= severe, ideation AND plan, with intent or means; na= not assessed)

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

Current Impairments:

(please select/circle one value for each type of impairment)

Key: 0=none, 1=mild or mildly incapacitating, 2=moderate or moderately incapacitating, 3= severe or severely incapacitating, na = not assessed for this impairment

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

Select one: ❑Gain ❑Loss ❑na of _____ pounds in last three months

Current weight = _____ lbs. ❑na Height = _____ ft. _____ inches ❑na

Medical/Physical Conditions	0	1	2	3	na
Substance Abuse/Dependence	0	1	2	3	na

Select all that apply: ❑Alcohol ❑Illegal drugs ❑Prescription Drugs

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

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Diagnosis:

Axis I: 1. _____ 2. _____

Axis II: 1. _____ 2. _____

Axis III: 1. _____ 2. _____

Axis IV: _____

Axis V: Current GAF = _____ Highest GAF in the past year = _____

Treatment History:

(please select all that apply)

Psychiatric Treatment in the Past 12 Months, excluding current course of treatment:

❑None ❑Unknown ❑Outpatient ❑Partial/IOP ❑Inpatient/Residential/Group Home

Outcome: ❑Unknown ❑Improved ❑No change ❑Worse

Treatment Compliance (Non-Med): ❑ unknown ❑ poor ❑ fair ❑good

Substance Abuse Treatment in Past 12 Months, excluding current course of treatment:

❑None ❑Unknown ❑Outpatient ❑Partial/IOP ❑Inpatient/Residential/Group Home

Outcome: ❑Unknown ❑Improved ❑No change ❑Worse

Treatment Compliance (Non-Med): ❑ unknown ❑ poor ❑ fair ❑good

Treatment Plan:

Reason for continued treatment: *(please select all that apply)*

❑Remains symptomatic ❑Prepare for discharge within coming month

❑Maintenance ❑Facilitate return to work

*Please indicate type(s) of service provided **BY YOU**, and the 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 _____

*Please indicate type(s) of service provided **BY OTHERS** (select all that apply):*

❑Medication Management ❑Indiv. Psychotherapy ❑Family Psychotherapy

❑Group Therapy ❑Community Prgrm(s) ❑Self Help Group(s)

Are the Member's family/supports involved in treatment? ❑Yes ❑No

Coordination of care with other behavioral health providers? ❑Yes ❑No

Coordination of care with medical providers? ❑Yes ❑No

Has Member been evaluated by a Psychiatrist? ❑Yes ❑No

Current Psychotropic Medications:

	Dosage	Frequency	Usually adherent?
1.			❑Yes ❑No
2.			❑Yes ❑No
3.			❑Yes ❑No

Treating Provider's Signature: _____ Date: _____