VALUEOPTIONS

# OUTPATIENT REVIEW FORM (ORF 2)

**Requested Start Date for this Authorization** ____/____/____
*NOTE: This form cannot be used to request ECT or psychological testing.*

Type of Service Requested: ❑ Mental Health ❑ Substance Abuse

**Patient Name:** _____

Date of Birth: _____ Age: _____ ❑ M ❑ F

Address (City/State only): _____Tel #: _____

Patient's Insurance ID#: _____

Patient's Employer/Benefit Plan: _____

**Provider Name:** _____License _____

Provider Program/Clinic (if applicable): _____

VO Provider # (if known): _____

Service Address: _____Tel #: _____

City/State/Zip: _____

Are you independently licensed to provide services in the State where you are treating this patient? ❑ Yes ❑ No

ID #: _____ *Check Which*: ❑ SSN ❑ Tax ID ❑ NPI

- Is patient currently receiving disability benefits? ❑ Y ❑ N ❑ Unknown

*The patient's chart reflects that:*

- I am treating this patient according to VO treatment guidelines. ❑ Y ❑ N ❑ NA
- I am coordinating this patient's case with other providers as appropriate. Behavioral: ❑ Y ❑ N ❑ NA Medical: ❑ Y ❑ N ❑ NA
- The treatment plan was developed with the patient and has measurable, time-limited goals. ❑ Y ❑ N ❑ NA

**Diagnosis**:

Axis I: 1. _____ 2. _____
Axis II: 1. _____ 2. _____
Axis III: 1. _____ 2. _____
Axis IV: 1. _____ 2. _____
Axis V: Current GAF = _____ Highest GAF in the past year = _____

**Treatment History**: (*please select all that apply*)

Previous Treatment in the Past 12 Months, excluding current course of treatment:
Type: ❑ Mental Health ❑ Substance Abuse ❑ Both ❑ None ❑ Unknown
❑ Outpatient ❑ Partial/IOP ❑ Inpatient ❑ Residential ❑ Group Home ❑ Other
Outcome: ❑ Unknown ❑ Improved ❑ No Change ❑ Worse
Treatment Compliance (Non-Med): ❑ Unknown ❑ Poor ❑ Fair ❑ Good

**Current Risk Assessment:** *(Please select/circle one value 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 either intent or means; na = not assessed)*

| | | | | | |
|---|---|---|---|---|---|
| Patient's risk to self: | 0 | 1 | 2 | 3 | na |
| Patient's risk to others: | 0 | 1 | 2 | 3 | na |

**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 Disturbance (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 Change Associated with a Behavioral Diagnosis | 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 Condition | 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/Relationship/Marital/Family Problems | 0 | 1 | 2 | 3 | na |
| Legal Problems | 0 | 1 | 2 | 3 | na |

**Treatment Plan:** *Reason for continued treatment (please select primary reason)*

❑ 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 _____ |
| ❑ Indiv. Psychotherapy w/Med Mgmnt 90807 | ❑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 Patient's family/supports involved in treatment? ❑ Yes ❑ No
Has Patient been evaluated by a psychiatrist: ❑ Yes ❑ No

| **Current Psychotropic Medications**: | Dosage | Frequency | Usually adherenet? | |
|---|---|---|---|---|
| 1. | | | ❑ YES | ❑ NO |
| 2. | | | ❑ YES | ❑ NO |
| 3. | | | ❑ YES | ❑ NO |

**Treating Provider's Signature**: _____

Date: _____