# VALUEOPTIONS OUTPATIENT REVIEW FORM (ORF 2)

**START HERE⇨** **Requested Start Date for this authorization:** ____________

**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

Attending Provider Name/Medicaid #: ____________

Billing Provider Name/ Medicaid #: ____________

Referring MD/LME/Medicaid #: ____________

Service Address: ____________

Attending 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)*

*KeyK 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 past year = ________

## ASAM Dimensions:

| | | | |
|---|---|---|---|
| 1: Intoxicated/WD Potential | ❑Lo❑Med❑Hi | 4: Readiness to Change | ❑Lo❑Med❑Hi |
| 2: Biomedical Conditions | ❑Lo❑Med❑Hi | 5: Relapse Potential | ❑Lo❑Med❑Hi |
| 3: Emot/Beh/Cog Condtns | ❑Lo❑Med❑Hi | 6: Recovery Environment | ❑Lo❑Med❑Hi |

## 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: ____________