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

Attending Provider Name/Medicaid #: ______________________

Agency/Group Name/Medicaid #: ______________________

Referring MD Name/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)*

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

ORF2 - NCSC version 1.6.06

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: __________