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: _____