Outpatient Review Form (ORF 2)

Requested Start Date for this authorization (mo/day/year):
Select type of service requested: ☐ mental health ☐ substance abuse

Provider and Member Demographics:
Member's Name:
Date of Birth (mo/day/year): Member's ID #:
Member's addresss (city and state only):
Insured's Employer/Benefit Plan:
Is member currently receiving disability benefits? ☐ yes ☐ no ☐ unknown

Attending Provider Name/Medicaid Provider Number:
Billing Provider Name/Medicaid Number:
Referring MD/LME/Medicaid Number:
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, 2=moderate, ideation with either plan or history of attempts; 3=severe, ideation AND plan, with either intent or means; na=not assessed for this impairment.

Risk to Self (SI): <select one>

Risk to Others (HI): <select one>

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.

<select one> Mood disturbances (depression or mania)
<select one> Anxiety
<select one> Psychosis/hallucinations/delusions
<select one> Thinking/cognition/memory/concentration problems
<select one> Impulsive/reckless/aggressive behavior
<select one> Activities of Daily Living problems
<select one> Weight loss associated with eating disorder:
☐ gain ☐ loss ☐ na of pounds in last 3 months.
Current weight: pounds. ☐ n/a
Height: feet inches. ☐ n/a
<select one> Medical/physical condition(s)
<select one> Substance abuse/dependence: *select all that apply:*
☐ alcohol ☐ illegal drugs ☐ prescription drugs
<select one> Job/school performance problems
<select one> Social/relationship/marital/family problems
<select one> Legal problems

Diagnosis: (ICD-10)

Diagnostic category 1: 1) 2)
2: 1) 2)
3: 1) 2)
4: 1)
5: Current GAF: Highest GAF in past year:

ASAM Dimensions:

1. Intoxicated/WD potential: <select one.
2. Biomedical conditions: <select one.
3. Emot/Beh/Cog conditions <select one.
4.Readiness to change: <select one.
5.Relapse potential: <select one.
6. Recovery environment: <select one.

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: <select one.
Treatment compliance (non-med): <select one.
Substance abuse treatment in the past 12 months, excluding current course of treatment:
☐ None ☐ Unknown ☐ Outpatient ☐ Partial/ ☐ Inpatient/residential/group home
IOP Outcome: <select one.
Treatment compliance (non-med): <select one.

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 ☐ weekly ☐ monthly ☐ quarterly ☐ other:
☐ Indiv.Psychotherapy (20-30 min) 90804 ☐ weekly ☐ monthly ☐ quarterly ☐ other:
☐ Indiv.Psychotherapy (45-50 min) 90806 ☐ weekly ☐ monthly ☐ quarterly ☐ other:
☐ Family Psychotherapy (45-50 min) 90847 ☐ weekly ☐ monthly ☐ quarterly ☐ other:
☐ Group Therapy (60-90 min) 90853 ☐ weekly ☐ monthly ☐ quarterly ☐ other:
☐ Other:
☐ Other:

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

☐ Medication management ☐ Indiv.Psychotherapy ☐ Family Psychotherapy
☐ Group Therapy ☐ Community Program(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:

Med #1: Dose: Frequency: Usually adherent? ☐ Yes ☐ No
Med #2: Dose: Frequency: Usually adherent? ☐ Yes ☐ No
Med #3: Dose: Frequency: Usually adherent? ☐ Yes ☐ No

Full name of treating provider:

Date (mo/day/year):