OUTPATIENT REGISTRATION FORM (ORF 1)

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 behavioral/medical providers as appropriate. ❑ Y ❑ N ❑ NA
- The treatment plan was developed with the patient and has measurable, time-limited goals. ❑ Y ❑ N ❑ NA

DSM-IV Diagnosis:
Please indicate primary diagnosis:
Axis I _____ Axis II: _____

Medical Conditions (Axis III): *Please check patient's medical conditions*
❑ None ❑ Asthma/COPD ❑ Cancer ❑ Cardiovascular Problems
❑ Chronic Pain ❑ Dementia ❑ Diabetes ❑ Obesity
❑ Other: _____

Current Risk Assessment:
Scale:: 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
(Please select/circle one value for each type of risk)

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
Medical/Physical Condition	0	1	2	3	na
Substance Abuse/Dependence	0	1	2	3	na
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

REQUESTED SERVICES: *Please indicate type(s) of service provided and 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 _____

Treating Provider's Signature: _____

Date: _____