

## OUTPATIENT REGISTRATION FORM (ORF 1)

Please complete all sections for submission to Value Behavioral Health.  
TYPE or PRINT LEGIBLY. Check/circle response where applicable.

Please fax completed form to **(724) 744-6329**.

**Member and Provider Demographics:**

Member's Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Member's Age: \_\_\_\_\_ Gender:  M  F  
 Member's Address (City/State only): \_\_\_\_\_  
 MAID # \_\_\_\_\_  
 Provider Name: \_\_\_\_\_  
 Provider Program/Clinic (if applicable): \_\_\_\_\_  
 Provider ID # (if known): \_\_\_\_\_  
 Service Address: \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Provider Telephone#: \_\_\_\_\_

**DSM-IV Diagnosis and Risk Assessment:**

Please indicate primary diagnosis:

Axis I: \_\_\_\_\_ Axis II: \_\_\_\_\_

**Current Risk Assessment:**

Scale: 0=none; 1=moderate, 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)

Member's risk to self:	0	1	2	3	na
Member's risk to others:	0	1	2	3	na

**Medical Conditions (Axis III):**

Please circle Member's medical conditions:

None/Other	Asthma	Chronic pain	Cancer
Cardiovascular problems	Diabetes	Pulmonary disease	

**Current Impairments: (please select/circle one value for each type of impairment)**

Scale: 0=none 1=mild/mildly incapacitating 2=moderate/moderately --moderatelmoderately incapacitating

**3= severe or severely incapacitating na = not assessed**

<b>Mood Disturbances (Depression or Mania)</b>	0	1	2	3	na
Anxiety	0	1	2	3	na
<b>Psychosis/Hallucinations/Delusions</b>	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
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/Relationships/Marital/Family Problems	0	1	2	3	na
<b>Legal Problems</b>	0	1	2	3	na

**Requested Services:**

Requested Start Date for this registration: \_\_\_\_\_

Please indicate type(s) of service provided and frequency.

- |  |                               |                                 |                                |                                      |
|--|-------------------------------|---------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Medication Management | <input type="checkbox"/> Wkly | <input type="checkbox"/> Mnthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Indiv. Psychotherapy  | <input type="checkbox"/> Wkly | <input type="checkbox"/> Mnthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Indiv. Psychotherapy  | <input type="checkbox"/> Wkly | <input type="checkbox"/> Mnthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Family Psychotherapy  | <input type="checkbox"/> Wkly | <input type="checkbox"/> Mnthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Group Therapy         | <input type="checkbox"/> Wkly | <input type="checkbox"/> Mnthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Psych Eval            | <input type="checkbox"/> Wkly | <input type="checkbox"/> Mnthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> IOP                   | <input type="checkbox"/> Wkly | <input type="checkbox"/> Mnthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> PHP                   | <input type="checkbox"/> Wkly | <input type="checkbox"/> Mnthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Clorazil              | <input type="checkbox"/> Wkly | <input type="checkbox"/> Mnthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> ICM                   | <input type="checkbox"/> Wkly | <input type="checkbox"/> Mnthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> RC                    |                               |                                 |                                |                                      |
| <input type="checkbox"/> Other _____           |                               |                                 |                                |                                      |

Treating Provider's Signature: \_\_\_\_\_

Date: \_\_\_\_\_