VALUEOPTIONS®
MARYLAND

OUTPATIENT CONCURRENT REVIEW

Level of Care: Outpatient Non-OMS ONLY

Demographics:
Consumer's Name: Date of Birth (mo./day/year):
Consumer ID #: Telephone Number#:
Consumer's City/State:
Provider Name: Provider VO ID:
Provider Address (Street/City/State):
Contact Name:
Contact Phone #:

Responsible Party:
If consumer is an adult, does the consumer have a legal guardian?
☐ Yes ☐ No

Parent/Guardian/Social Services/Juvenile Services Contact Information:
First Name: Last Name:
Address:
Phone Number:

If consumer is a juvenile, does the guardian listed have legal custody of the consumer?
☐ Yes ☐ No

Services Requested:
Psychotherapy: (90801 , 90804, 90806, 90807, 90847, 90849, 90853, 90857, 90876)
Medication Management: (90801 , 90805, 90807, 90862)

Units requested:

Requested Start Date for this Authorization (mo./day/year):

Required Data:
Race: ☐ White ☐ Asian ☐ American Indian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ N/A

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ N/A

Education (if child, grade attended in the last 3 months - if adult, highest level of school completed): ☐ 0 yrs. ☐ Nursery School ☐ Self-Contained Special Education Class ☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ Trade, Vocational, or Technical School ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐ College freshman ☐ College sophomore ☐ College junior ☐ College senior ☐ Graduate school ☐ unknown

Number of arrests within the past 30-days (0-99): _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Living Situation: ☐ Family Home ☐ Foster Home ☐ Treatment Foster Home ☐ Group Home ☐ On his/her own ☐ Other congregate Care Setting ☐ Jail/Correctional facility ☐ Homeless Shelter ☐ Other ☐ N/A

Employment status: ☐ Competitive Employment ☐ Supported Employment ☐ Unemployed-looking for work ☐ Retired ☐ Sheltered Employment ☐ Sheltered Workshop ☐ Homemaker ☐ Volunteer ☐ Disabled now- not in workforce ☐ Not seeking work ☐ N/A

Is consumer a Veteran? ☐ Yes ☐ No
If yes, what is most recent war served: ☐ Afghanistan ☐ Iraq ☐ Other

Is this a transition age consumer? ☐ Yes ☐ No

DSM-IV Diagnosis:
Axis I: I) 2)
Axis II: I) 2)
Axis III: I) 2)
Axis IV:
Axis V: Current GAF: Highest GAF previous year:

Current Risks:
Risk Level Scale. 0=none, 1=mild, 2=moderate, ideation with either plan or history of attempts; 3=severe, ideation AND plan, with either intent or means; n/a=not assessed). Choose risk level for each category, and check all boxes that apply:

Risk to Self (SI):	☐0	☐1	☐2	☐3	☐n/a	with	☐ideation	☐intent	☐plan	☐means
Risk to Others (HI):	☐0	☐1	☐2	☐3	☐n/a	with	☐ideation	☐intent	☐plan	☐means

Current serious attempts: ☐Yes ☐No Choose: ☐SI ☐HI
Prior serious attempts: ☐Yes ☐No Choose: ☐SI ☐HI
Prior serious gestures: ☐Yes ☐No Choose: ☐SI ☐HI

Date of the most recent attempt or gesture (mo/day/yr):

CONSUMER'S NAME:

Current Impairments:
Scale: 0=none, 1=mild, 2=moderate, 3=severe, n/a = not assessed

☐0 ☐1 ☐2 ☐3 ☐n/a Mood disturbance (depression or mania)
☐0 ☐1 ☐2 ☐3 ☐n/a Anxiety
☐0 ☐1 ☐2 ☐3 ☐n/a Psychosis
☐0 ☐1 ☐2 ☐3 ☐n/a Thinking/cognition/memory
☐0 ☐1 ☐2 ☐3 ☐n/a Impulsive/reckless/aggressive
☐0 ☐1 ☐2 ☐3 ☐n/a Activities of Daily Living
☐0 ☐1 ☐2 ☐3 ☐n/a Weight loss assoc. w/behavioral Dx: ☐ gain ☐ loss ☐ n/a of
Pounds in last 3 months: Current Weight: lbs
Current Height ft inches

☐0 ☐1 ☐2 ☐3 ☐n/a Medical/physical condition(s)
☐0 ☐1 ☐2 ☐3 ☐n/a Substance abuse/dependence
☐0 ☐1 ☐2 ☐3 ☐n/a Job/school performance
☐0 ☐1 ☐2 ☐3 ☐n/a Social/marital/family problems
☐0 ☐1 ☐2 ☐3 ☐n/a Legal

Mental Health/Psychiatric Treatment History: *(Please check all that apply)*
☐ None ☐ Unknown

☐ Outpatient: *If "Outpatient" is checked, please indicate:*
Outcome: ☐ Unknown ☐ Improved ☐ No Change ☐ Worse
Treatment compliance (non-med): ☐ Unknown ☐ Poor ☐ Fair ☐ Good

☐ IOP/Partial: *If "IOP/Partial" is checked, please indicate:*
Outcome: ☐ Unknown ☐ Improved ☐ No Change ☐ Worse
Treatment compliance (non-med): ☐ Unknown ☐ Poor ☐ Fair ☐ Good

☐ Inpatient/Residential/Group Home: *If "Inpatient/Residential/Group Home" is checked, please indicate:*
Outcome: ☐ Unknown ☐ Improved ☐ No Change ☐ Worse
Treatment compliance (non-med): ☐ Unknown ☐ Poor ☐ Fair ☐ Good
Number of psychiatric hospitalizations in the past 12 months:

Substance abuse Treatment History: *(Please check all that apply)*
☐ None ☐ Unknown

☐ Outpatient. *If "Outpatient" is checked, please indicate:*

Outcome: ☐ Unknown ☐ Improved ☐ No Change ☐ Worse
Treatment compliance (non-med): ☐ Unknown ☐ Poor ☐ Fair ☐ Good

☐ IOP/Partial. *If "IOP/Partial" is checked, please indicate:*

Outcome: ☐ Unknown ☐ Improved ☐ No Change ☐ Worse
Treatment compliance (non-med): ☐ Unknown ☐ Poor ☐ Fair ☐ Good

☐ Inpatient/Residential. *If* "Inpatient/Residential" *is checked, please indicate:*

Outcome: ☐ Unknown ☐ Improved ☐ No Change ☐ Worse
Treatment compliance (non-med): ☐ Unknown ☐ Poor ☐ Fair ☐ Good

Number of substance abuse hospitalizations in the past 12 months:

Other Treatment History: *(Please check all that apply)*

Criminal justice involvement in the last 12 months? ☐ Yes ☐ No
Currently on probation? ☐ Yes ☐ No
History of sexually inappropriate/aggressive behavior? ☐ Yes ☐ No
History of fire setting in the last 12 months? ☐ Yes ☐ No
Active gang involvement in the last 12 months? ☐ Yes ☐ No
DSS/CPS involvement in the last 12 months? ☐ Yes ☐ No
Victim of sexual or physical abuse? ☐ Yes ☐ No

Current psychotropic meds? ☐ Yes ☐ No *If yes, please complete below:*

Current Psychotropic Medications:

Meds.	Dose	Freq.	Usually Adherent?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

CONSUMER'S NAME:

Substance Use/Abuse: ☐ No ☐ Yes ☐ Unknown. *If yes, please complete below:*

Substance	Length Curr. use	Amount	Freq.	Date Last Used

Is family/couples therapy indicated? ☐ Yes ☐ No If yes, date of appointment (mo/day/year):

☐ Involuntary ☐ Court Ordered ☐ Fixed length program *(specify length:*)
Frequency of program = per

Reason for Continued Treatment: ☐ remains symptomatic ☐ conduct family therapy ☐ stabilize medications ☐ has not achieved treatment goals ☐ finalize discharge plan ☐ other:

Agencies Involved
Does member have any state agency affiliation? ☐ Yes ☐ No ☐ Unknown

Protective services (Adult or child) ☐
Local Department of Social Services (DSS) ☐
Homeless Services ☐
Parole and Probation ☐
County Funded Mental Health ☐
Department of Juvenile Services (DJS) ☐
Division of Rehabilitation Services ☐
Other (self-rehab, supported groups, etc.) ☐

Description of Current Agency Services/Contact Information:

History of Services

TREATMENT/REHABILITION/SERVICE PLAN GOALS

I am treating this consumer according to VO treatment guidelines ☐ Yes ☐ No

I am coordinating this consumer's case with other behavior/medical providers as appropriate ☐ Yes ☐ No

The treatment plan was developed with the consumer and has measurable time limited goals ☐ Yes ☐ No

Consumer/Guardian involved in Treatment plan? ☐ Yes ☐ No

Was Consumer given a copy of this treatment plan? ☐ Yes ☐ No

Date of Plan

Long Term Goals:

CONSUMER'S NAME:

Strengths and Skills

Consumer Expectations and Responsibilities

Identify Consumer's Supports

Individual's Hope for Recovery (in consumer's own words)

Goal 1:
Short Term Goal Target Date

Short Term Goal #1

Intervention

Update on Progress

Goal 2:
Short Term Goal Target Date

Short Term Goal #2

Interventions

Update on Progress

CONSUMER'S NAME:

Goal 3:
Short Term Goal Target Date

Short Term Goal #3

Interventions

Update on Progress

Goal 4:
Short Term Goal Target Date

Short Term Goal #4

Interventions

Update on Progress

Discharge Plan

Expected Discharge Date:

Responsible Staff:

1.

2.

3.

4.

Signature of person completing this form: Date (mo/day/year)