**EHS Support Services—Outpatient Referral Form**

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| **DATE OF REFERRAL:** |  |

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| **CLIENT DEMOGRAPHIC, INSURANCE, AND DIAGNOSTIC INFORMATION** |
| **Name:** |  | **Date of Birth:** |  |
| **Address:** |  |
| **Home Phone:** |  | **Gender:** |  |
| **Cell Phone:** |  | **Race:** |  |
| **Work Phone:** |  | **Marital Status:** |  |
| **Social Security Number:** |  | **Medicaid Number:** |  |
| **Other Insurance (Name & Number):** |  |

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| **LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/POA INFORMATION (If Applicable)** |
| **Name:** |  | **Relationship:** |  |
| **Address:** |  |
| **Home Phone:** |  | **Cell Phone:** |  | **Work Phone:** |  |

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| **Chief Complaint/Presenting Problem:** |  |

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| **DIAGNOSTIC INFORMATION:** |
| **Axis 1;** |  |
| **Axis II:** |  |
| **Axis III:** |  |
| **Axis IV:** |  |
| **Axis V:** |  |

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| **PLEASE CHECK ALL PROBLEM AREAS THAT APPLY TO THIS CLIENT:** |
|  | Depression |  | Domestic Violence |  | Parenting |  | Substance/Alcohol Use/Abuse |
|  | Anger/Aggression |  | Family/Relationship Issues |  | Custody Issues |  | Accessing Medical/Dental Care |
|  | Anxiety |  | Medication Management |  | Difficulty Sleeping/Eating |  | Accessing Needed Resources |
|  | Expressing Feelings/Emotions |  | Stabilize Psychiatric Symptoms |  | Racing thoughts |  | Address Safety & Security Issues |

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| **CRITERIA FOR PARTICIPATION (Must meet ALL of the following criteria)** |
|  | **Does the client require treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels, which have been impaired?** |
|  | **Does the client exhibit one or more of the following:****• Deficits in peer relations or in dealing with authority****• Hyperactivity****• Poor impulse control****• Clinical Depression****• Problems with attention and concentration, the ability to learn, or the ability to participate in employment, educational, or social activities.** |
|  | **Is the client at risk for developing or requires treatment for maladaptive coping strategies?** |
|  | **Does the client present a reduction in individual adaptive and coping mechanism or demonstrate extreme increase in personal distress?** |
| **Describe:** |  |

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| **REFERRING PARTY NAME:** |  | **REFERRING AGENCY:** |  |
| **MAILING ADDRESS:** |  |
| **TELEPHONE NUMBER:** |  | **E-MAIL ADDRESS:** |  |

**EHS OFFICE USE:**

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| **PRE-AUTH NEEDED? (YES OR NO):** |  | **ACTIVE INSURANCE COVERAGE? (YES OR NO):** |  |
| **DATE PRE-AUTH REQUESTED:** |  | **PATIENT COPAY:** |  |
| **DATE APPROVAL RECEIVED:** |  | **WELCOME PLAN SENT:** |  |
| **APPOINTMENT (DATE/TIME):** |  | **PROVIDER:** |  |