



Omni
COMMUNITY HEALTH

Referral Information Form

Identifying Information

Date of Referral:		
Client Name:		Date of Birth:
SS Number:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Race: <input type="checkbox"/> White <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Other:		
Address:		Work/School:
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Current Caretaker or Spouse and Relationship:		
Emergency Contact Name/Phone/Address:		

Referral Source Information

Name:	Title:	Email:
Agency:	Phone Number:	Fax Number:

Requested Level of Care

<input type="checkbox"/> Outpatient Counseling (Ind. and/or Family Therapy)	<input type="checkbox"/> Diagnostic & Evaluation Services	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Case Management (Home/Community/School Support)
<input type="checkbox"/> Intensive Outpatient Program (Behavioral/Mental Health IOP ages 8-17)	<input type="checkbox"/> CCFT (intensive in-home support for children at risk of removal from home due to child's behaviors)		
<input type="checkbox"/> Other:			

Funding Source

<input type="checkbox"/> United Healthcare	<input type="checkbox"/> BlueCare	<input type="checkbox"/> BCBS	<input type="checkbox"/> Other:	Commercial Insurance needed: Policy ID: Group ID: Policy Holder: Holder's DOB: Holder's SS: Verification phone number on back of card:
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Please fax completed form ATTN: Admissions 1-800-309-1601 or e-mail admissions@omnicommunityhealth.com.
If you have additional questions, contact us at 1-866-321-9111 or visit us at www.omnicommunityhealth.com.



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Presenting Problems

<input type="checkbox"/> Sexually Acting Out	<input type="checkbox"/> Verbal Aggression	<input type="checkbox"/> Homicidal Ideation
<input type="checkbox"/> Drug Possession/Drug Use	<input type="checkbox"/> Physical Aggression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Runaway	<input type="checkbox"/> Destruction to Property	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Hallucination/Psychosis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Stealing/Theft	<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/> Academic Problems
<input type="checkbox"/> Mood Disturbance	<input type="checkbox"/> Grief-Related Issues	<input type="checkbox"/> Hx of Physical Abuse
<input type="checkbox"/> Defiance	<input type="checkbox"/> Abandonment Issues	<input type="checkbox"/> Hx of Sexual Abuse
<input type="checkbox"/> Legal Difficulties	<input type="checkbox"/> Sleep Disturbance	

Medical & Treatment History

Please list any current or past medical problems:
Current Medications:
Describe any current or past treatment or involvement with mental health services:

Other Information

Please list any additional comments/concerns:
