REFERRAL

☐ **OUTPATIENT THERAPY** ☐ **PRP**

IDENTIFYING INFORMATION: **Date of Referral:**

Consumer's Name:		**Date of Birth:**		**Age:**	
Address:		**Social Security:**		**Gender:**	☐ Male ☐ Female
City, State, Zip:		**Medical Assistance #:**			
Contact #:		**Current Grade:**			
Employment Status:	☐ **EMPLOYED** ☐ **STUDENT** ☐ **OTHER**	**Race/Ethnicity:**			
Marital Status:		**Language Spoken:**			
Veteran Status:		**Living Situation**	☐ **Private Residence** ☐**Homeless** ☐ **Other:**		
Adult Contact's Name: **Phone Number:**		**Relationship:**	☐ **Parent** ☐ **Guardian** ☐ **Foster Care Provider** ☐ **Other:**		

DSM V DIAGNOSES: (A minor must have a behavioral diagnosis and be referred by a Licensed MH Professional to be eligible for PRP – An adult's diagnosis must meet the Priority Population and be referred by a Licensed MH Professional to be eligible for PRP)

Behavioral Diagnoses: *(ICD-IO Diagnosis Code Required)*	Diagnosis Code:		Description:	
	Diagnosis Code:		Description:	
	Diagnosis Code:		Description:	
Primary Medical Diagnoses: *(Required)*	Description:			
	Description:			
Social Elements Impacting Diagnoses: *(Required)*	☒ Educational ☐ Financial Access to Health Care ☐ Legal System/Crime ☒ Occupational Social Environment ☒ Primary Support ☐ Housing ☐ Homelessness ☒ *Other Psychosocial & Environmental ☐ None ☐ Unknown **Explain "Other Psychosocial & Environmental elements":*			

CLINICAL INFORMATION:

Date of Last Therapy Appointment: 5/12/2021	**Frequency of Treatment: ☐WEEKLY ☐ BI-WEEKLY ☐ MONTHLY**
Has the individual been engaged in active, documented outpatient treatment for:	**☐ BETWEEN 1-5 MONTHS ☐ BETWEEN 6-12 MONTHS ☐ MORE THAN 12 MONTHS**
In the past three (3) months, how many ER visits has the individual had for psychiatric care?	**☐ 0 VISITS ☐ 1 VISIT ☐ 2 OR MORE VISITS**
Is the individual transitioning from an inpatient, day hospital or residential treatment setting to a community setting?	**Has medication been considered for this individual?** **☐ NOT CONSIDERED ☐ CONSIDERED & RULED OUT ☐ONGOING.** **☐ INTIATED & WITHDRAWN ☐ OTHER:** **Treating Psychiatrist _____**

One Source Wellness Works

REFERRAL FORM

Has client attended school/college in the last 3 months?	**Yes**	**No**
Has client been arrested in the last 30 days?	**Yes**	**No**
Has client had a psych hospitalization in the last 30 days?	**Yes**	**No**
Is client a transition youth age consumer?	**Yes**	**No**
Is client an active participant in therapy at this time?	**Yes**	**No**
Does client speak secondary language at home?	**Yes**	**No**
Is the client deaf or do they have serious difficulty hearing?	**Yes**	**No**
Is the client blind or do they serious difficulty seeing even when wearing glasses?	**Yes**	**No**
Because of physical, mental, or emotional condition, does the client have serious difficulty concentrating, remembering, or making decisions (*5 yrs or older*)?	**Yes**	**No**
Does the client have difficulty walking or climbing stairs (*5 yrs or older*)?	**Yes**	**No**
Does the client have difficulty dressing and/or bathing? (*5 yrs or older*?	**Yes**	**No**

PLEASE CHECK ALL AREAS THAT ARE APPLICABLE TO INDIVIDUAL NEEDS:

	Activities of Daily Living		Anger/Temper/Conflict Resolution
	Assertiveness/Self Esteem		Community Activity
	Family/ Natural Supports		Finances
	Home/Housing		Self Care Skills
	Safety to Self/Others		School Performance
	Sexual Issues		Social Skills/Peer Interaction
	Substance Abuse Issues		Coping Skills
	Trauma		Medication Management
	Vocational Skills		Leisure Skills
	Work/Job Performance		Legal Issues
	Money Management		Dietary/Food Preparation
	Crisis Management Skills		Physical Health
	Educational Support		Suicidal Risk
	Entitlements		

REFERRAL FORM

CLINICAL SUMMARY: *(Indicate presenting issues the individual is presenting)*

LICENSED MENTAL HEALTH PROFESSIONAL PROVIDING REFERAL:

Name & Credentials:		**Agency/Organization:**	
Email:		**Phone Number:**	
Supervisor's Name & Credentials:		**Supervisor's Email:**	
Signature: **Date:**			

ONCE YOU HAVE COMPLETED THIS FORM PLEASE SUBMIT VIA WEB PORTAL, FAX FORM AND ALL APPLICABLE DOCUMENTS TO
One Source Wellness Works LLC @833-694-0657 Fax
OR EMAIL TO admin@onesourcewellnessworks.com

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