



Outpatient Behavioral Health Clinic Registration/Referral Form

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| Name of person seeking services (Last, First): | | DOB: | Age: |
| Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____ | | SSN: | |
| Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other Specify _____ | Gender: | Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Other _____ | |
| Primary Telephone# : <input type="checkbox"/> okay to leave message | Secondary Telephone # <input type="checkbox"/> okay to leave message | | |
| Address: | City: | State: | Zip Code: |
| Name of Legal Guardian: <input type="checkbox"/> N/A | Legal Guardian's Telephone #: | | |
| Legal Guardian's Address: | City: | State: | Zip Code: |
| Name of Referral Source: <input type="checkbox"/> Self | Referring Agency/ Program: | Phone Number of Referral Source: | |
| Emergency Contact: | | Telephone #: | |
| Why are you seeking services? <i>(Psychiatry and health monitoring services are offered ancillary to therapy services only)</i> | | | |
| Do you expect to need psychotropic medications within the next 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are you currently receiving mental health or chemical dependency treatment services? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, where? | | |
| Have you received services at the OCMS Clinic before? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Last agency where you received services? | | Date? For how long? | |
| Are you receiving SSI? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you been previously diagnosed by a mental health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list Primary Diagnosis: _____ | | |
| Primary Insurance: | Name: | ID # : | |
| Secondary Insurance: | Name: | ID # : | |
| PAM/CFA Coach: | PAM Level: | PAM Score: | |

