# Outpatient Behavioral Health Clinic Registration/Referral Form

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