Omni
COMMUNITY HEALTH

Referral Information Form

Identifying Information

Date of Referral:			
Client Name:			Date of Birth:
SS Number:			Gender: ☐ Male ☐ Female
Race: ☐ White ☐ African-American ☐ Hispanic ☐ American Indian ☐ 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

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

Funding Source

☐ United Healthcare	☐ BlueCare	☐ BCBS	☐ Other:	**Commercial Insurance needed:** Policy ID: Group ID: Policy Holder: Holder's DOB: Holder's SS: Verification phone number on back of card:

Please fax completed form ATTN: Admissions 1-800-309-1601or e-mail admissions@omnicommunityhealth.com.
If you have additional questions, contact us at 1-866-321-9111or visit us at www.omnicommunityhealth.com.

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Presenting Problems

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

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