NEW VISION BEHAVIORAL HEALTH SERVICES INC

OMHC-REFERRAL FORM

Date:_____

Individual Name:_____Age____D.O.B_____ SS#_____

Gender: [] Male [] Female [] Other _____

Admission:
Legal Status at Admission: [] Voluntary [] Involuntary civil [] Involuntary criminal

Living situation:
What is the individual's living situation:
[] Private residence [] Homeless/Emergency. Shelter [] Foster home [] Halfway House [] Boarding/rooming house
[] RRP, Group home/TGH [] Crisis Residence [] Assisted Living [] Skilled Nursing Facility [] Hospital
[] RTC for Children and Adolescents [] Jail/Correctional facility/Detention Center [] Other:
_____

Was the individual homeless in the last 6 months? [] Yes [] No

Current Address:

Address: _____City:_____ State: _____Zip:_____

Home Phone#:_____Cell#:_____Work #:_____

Email:_____

Marital Status and Pregnancy:
Marital Status: [] Single [] Married [] Divorce [] Separated [] Widowed
Pregnant: [] Yes [] No [] N/A

Referral Source:
[] Juvenile Justice Agency [] TASC/Diversionary Program [] DWI/DUI Referral [] Pre-Trial Service Agency
[] Probation [] Parole [] State Prison [] Local Detention/Jail [] MDH Drug Court [] Other Drug Court [] Other Court
[] Other Criminal Justice [] Individual/Self referral [] Parent/Guardian/Family [] Substance Related Disorder Care Provider
[] Mental Health Care Provider/Professional [] Other Health Care Provider [] School/Student Assistance Program
[] Employer//Employee Assistance Program [] Department of Human Services [] DSS Assessment Unit/TCA [] Psychiatric Hospital
[] Acute Care Hospital (ER, Inpatient) [] Other Community Referral [

Referral source Name:_____Address:_____

Phone#_____Relationship to Individual being referred;_____

If BCDSS referred request a copy of court order (must be obtained before individual can be seen for intake)

Individual General and Guardian Information:
What does the Individual Prefer to be called:_____
Please list any Previous Last Names (ex. Maiden Name):_____

Does the Individual Have a Legal Guardian? [] Yes [] No
If yes, complete guardian information
Name:_____Relationship:_____
Address: _____City:_____ State: _____Zip:_____
Home Phone#:_____Cell#:_____Work #:_____
Email:_____

Name: _____ D.O.B_____

Individual Required Data Elements:
Ethnicity & Race
Is the individual of Hispanic, Latina/o, or Spanish Origin? [] Yes [] No

Race:
[] White [] Black or African American [] American Indian or Alaska Native [] Asian Indian [] Chinese [] Filipino
[] Japanese [] Korean [] Vietnamese [] Other Asian [] Native Hawaiian [] Guamanian or Chamorro [] Samoan .
[] Other Pacific Islander
If the Individual is Multiracial, Select other Race(s):
[] White [] American Indian or Alaskan Native [] Asian [] Native Hawaiian or Other Pacific Islander [] Black or African American

Language:
How well does the individual Speak English? (ask if 5 years or older): [] Very well [] Well [] Not well [] Not at all
Does the Individual Need Assistance with Communicating in English? [] Yes [] No
Does the Individual Speak a Language other than English at Home? [] Yes [] No [] Not available

Education:
Highest grade completed: _____ Did the individual attend school anytime in the last 3 months? [] Yes [] No

Military/Veteran Status:
Is this individual, a veteran? [] Yes [] No [] Not available

Disability Status:
Is the individual deaf or hard of hearing? [] Yes [] No
Is the individual blind or having serious difficulty seeing even when wearing glasses? [] Yes [] No
Because of a physical, mental, or emotional condition, is the individual having difficulty concentrating, remembering, or making decisions? (5 years old or older). [] Yes [] No
Is the individual having serious difficulty walking or climbing stairs? **(5 years old or older**). [] Yes [] No
Is the individual having difficulty dressing or bathing? **(5 years old or older).** [] Yes [] No
Because of a physical, mental, or emotional condition, is the individual having serious difficulty doing errands alone? **(15 years old or older**).
[] Yes [] No

Insurance Type: [] Maryland Medicaid #_____MCO: _____
[] Medicare (Red, white and blue card) [] No [] Yes, If yes refer to Medicare.
[] Private insurance (CareFirst, Keiser Permanente, etc) [] No [] Yes, If yes refer individual to Insurance provider for assistance.
[] Uninsured. See if individual meets uninsured eligibility requirements and request uninsured span in Incedo.

Other information:
Employment Status: [] Employed [] Unemployed, seeking employment [] SSI [] Family [] Disability [] Seeking employment
Other source of income_____
Tobacco Use in the Past 30 Days: [] Yes [] No
Does the individual smoke cigarettes? [] Yes [] No
Was the individual screened for gambling? [] No [] Yes, gambling problem not indicated [] Yes, gambling problem included in treatment here? [] Yes, referral to gambling treatment center

Does the individual need accommodations in accordance with the American Disabilities Act (eg, sign language, interpreter, etc)
[] Yes [] No If yes, please explain:

Number of times in self-help support group in the past 30 days? (Alcoholic Anonymous (AA), Narcotics Anonymous (N/A) etc
[] No attendance [] Less than a week-1 to 3 times in the past 30 days
[] About once a week- 4 to 7 times in the past 30 days
[] 2 to 3 times per week-8-15 times in the past 30 days
[] At least 4 times/week- 16-30 times in the past 30 days
[] Some attendance-number of times and frequency is unknown.
[] Unknown

Name: _____ D.O.B_____

Individual Substance Use Information: (Please confirm individual's substance use history).
[] Yes, individual has a history of Substance use/
[] Individual Does not have a history of Substance use

Referral Information:

Type of service requested: [] Medication Management only, must obtain current therapist info.
[] Therapy only
[] Both Therapy and Medication Management

Current Psychiatric medication(s):
_____

Reason for referral: _____

Are you currently seeing a therapist, and or Psychiatrist elsewhere: [] No [] Yes
If yes, Name and title:_____
Agency:_____
Phone #: _____

Is referral upon discharge from an inpatient or crisis facility? [] No [] Yes, ***If yes, request a copy of the aftercare/ discharge summary.***

Emergency contact: _____Relationship_____Phone:_____

OFFICE USE ONLY:

Referral received by:_____

Based on the information given by individual , is the individual appropriate for treatment: [] Yes
[] No, If no, document action taken: informed individual,
[] Referral elsewhere_____ Other:_____