Out Stretched Hands Counseling Center, LLC (OSHCC) REFERRAL FORM

RETURN COMPLETED REFERRAL REQUEST FORM TO			
ATTENTION	Intake Coordinator	FAX	1-866-898-9031
PHONE	1-269-468-9803	EMAIL	ohsccenter@gmail.com (PLEASE SCAN AND EMAIL THIS REFERRAL WITH PATIENT SIGNED RELEASE/CONSENT)
FORM COMPLETED BY		PHONE	DATE

REFERRED BY			
REFERREE		PHONE	
SPECIALTY		FAX	
SIGNATURE		EMAIL	
PCP if different		PCP PHONE	

PATIENT INFORMATION			
LAST NAME		FIRST NAME AND MI	
DATE OF BIRTH		FEMALE / MALE	
INTERPRETER REQUIRED?		LANGUAGE REQUIRED	
GUARDIAN NAME		GUARDIAN RELATIONSHIP	
PATIENT'S ADDRESS		CELL PHONE	
		HOME PHONE	
		WORK PHONE	
		EMAIL	
REFERRAL DIAGNOSIS		ICD-9	

SERVICE REQUESTED					
REASON FOR REFERRAL					
PATIENT AWARE OF REASON FOR REFERRAL? IF NOT, PLEASE EXPLAIN.					
TYPE OF ASSESSMENT Needed (if any)		TYPE OF COUNSELING/GROUP			
SASSI-4 (CHILD/ADULT)		DVI ASSESSMENT		MENTAL HEALTH OR SUBSTANCE ABUSE/USE COUNSELING	
ADDITIONAL COMMENTS					

INSURANCE INFORMATION											
AUTHORIZATION REQUIRED?		YES		NO	AUTH #		# OF VISITS		AUTH EXP. DATE		
	PPO		HMO		OTHER	INSURANCE PLAN					
INSURANCE ID				MEDICAL GROUP			PHONE #				
INSURANCE HOLDER'S NAME				RELATIONSHIP TO PATIENT			DOB				