Allen-Ayuk Behavioral Health Center, LLC

OMHC REFERRAL FORM

Please complete form in its entirety; contact our office with any questions.

Name				Gender	○ Male ○ Female ○ Transgender
Address					
Phone	Home:		Cell:		Work:
D.O.B.		SSN		MA #	**Active:** Yes ○ No ○
Race				Marital Status	
Service being sought	☐ Counseling ☐ Psychiatry/Medication Management				

LEGAL GUARDIAN/CAREGIVER

Name		Relationship to client	
Contact information *(if different from above)*	Address: Phone:		

CURRENT CLINICIAN/PSYCHIATRIST

Name				Affiliated Clinic	
Address					
Phone		Fax		Email	
How long has client been in treatment with this clinician/psychiatrist?					
Diagnosis *(please include secondary if applicable)*	Primary: Secondary:				
Substance Abuse	○ Yes ○ No *If yes, indicate substance(s) of choice:*				
Suicidal	○ Yes ○ No *If yes, indicate history:*				
Homicidal	○ Yes ○ No *If yes, indicate history:*				

REASON for REFERRAL

Provide a brief description of the reason for referral to PRP. ***Select specific area(s) of need below.***	

Self-Care Skills	Social Skills	Independent Living Skills	Community Living Skills	Symptom Management
☐ Personal Hygiene	☐ Developing supports	☐ Money management	☐ Identifying resources	**Coping Skills for:**
☐ Nutrition	☐ Conflict resolution	☐ Maintaining living env't	☐ Entitlements	☐ Anger
☐ Physical Activity	☐ Boundary awareness	☐ Cooking/Shopping	☐ Housing	☐ Anxiety
☐ Personal Safety	☐ Interactive skills	☐ Time management	☐ Vocational	☐ Grief & Loss
				☐ Other:

REFERRED BY

Print Name & Credentials		Date of Referral	
Signature			