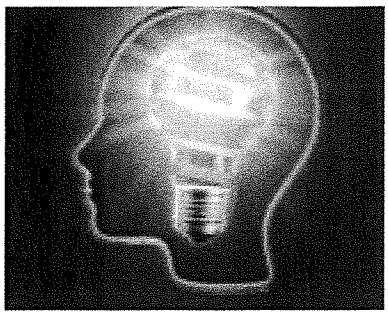


NEW VISION BEHAVIORAL HEALTH SERVICES INC, OMHC
"NEW PATH, NEW VISION"
5718 Harford Rd, Suite 103
Baltimore, MD 21214
Tel: 410-254-4343 Fax: 410-254-4342

OMHC-REFERRAL FORM

Date:_____

Admission: Legal Status at Admission: [ ] Voluntary [ ] Involuntary civil [ ] Involuntary criminal
Type of service requested: [ ] Medication Management **(must obtain current therapist info)** [ ] Therapy only [ ] Both Therapy and Med mgmt

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

Individual Name:_____ D.O.B_____ SS#_____

Address: _____City:_____ State: _____Zip:_____

Home Phone#:_____Cell#:_____Work #:_____

Email:_____

Marital Status: [ ] Single [ ] Married [ ] Divorce [] Separated [ ] Widowed
Pregnant: [ ] Yes [ ] No [ ] N/A
Gender: [ ] Male [ ] Female [ ] Other_____

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

BCDSS involvement: [ ] Yes [ ] No
If Yes, inform the referral source that a copy of court order must be obtained before the individual can be seen.

BCDSS worker name: _____***Phone #***_____

Individual General and Guardian Information:

What does the Individual Prefer to be called:_____ Preferred pronouns: _____

Please list any Previous Last Names (ex. Maiden Name):_____

Does the Individual Have a Legal Guardian? [ ] Yes [ ] No If yes, complete below guardian information:

Name:_____Relationship:_____

Address: _____City:_____ State: _____Zip:_____

Home Phone#:_____Cell#:_____Work #:_____

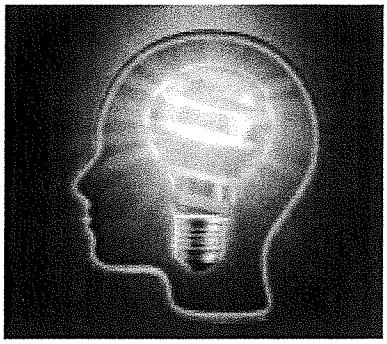
Email:_____

Emergency contact: _____Relationship_____ Phone:_____

Individual Required Data Elements:
Ethnicity & Race: Is the individual 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

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



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Name:_____ **D.O.B:**_____

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

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

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

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 Source: [ ] Juvenile Justice Agency [ ] TASC/Diversionary Program [ ] DWI/DUI Referral [ ] Pretrial Service Agency [ ] Probation [ ] Parole [ ] State Prison [ ] Local Detention/Jail [] MDH Drug Court [ ] Other Drug Court [ ] Other Court [ ] Other Criminal Justice [ ] Therapist [ ] 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) [ ] Medical Dr/PCP [ ] Psychiatrist [ ] Dentist [ ] Other Community Referral \

Referral Source Name: _____ Address: _____ Phone#_____

Relationship to Individual being referred: _____ Current Psychiatric medications: _____

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.***

OFFICE USE ONLY:

Referral received by: (New Vision staff): _____

Base on the information given by individual, is the individual appropriate for treatment: [] Yes
[] No, if no document action taken: [] informed individual of reason, and referral elsewhere, indicate where referred.
[] Other