Please send completed form to:

Fax: (580) 672-8010

Behavioral Health Services Referral Form

Thank you for your referral. Our agency will contact you to confirm that the referral has been received. Please discuss the nature and intent of this referral with your client. We will contact the client to schedule an appointment.

Referral Date:	Referral Contact Phone:	Referral Fax:
Referral Source (Name and Age	ency):	
Referral Address:		
Client Name:	Date of Birth:	Gender:
Guardian (If applicable):		
Address:		
Contact Home Phone:	Contact Alterna	te Phone:
Presenting Concerns/Comments (Attach sheets as necessary):		
	_	
Diagnosis (If known):		
Priority: Low (Schedule when available) High (Schedule as soon as possible) Emergency (Complete risk assessment)		
	available) Inigh (schedule as soon as pos:	sible) Emergency (Complete risk assessment)
Risk Assessment:		
Danger To Self None History but no recent intent, ideation, or feasible plan	Recent ideation, intention, plan that is feasible and/or history of a potentially lethal attempt.	Current ideation or command hallucinations of self harm, current intent, plan that is immediately accessible and feasible, and/or history of multiple potentially lethal attempts. Call 1 (800) 522-1090 immediately.
Danger To Others None History but no recent gesture or ideation	Recent ideation, or physically harmful aggression, but not in part to harm others.	feasible plan of physically harmful aggression,
Location of Services Requested:		
Ada Ardmore Durant Madill Marietta (0-21 Only)		
Pauls Valley Seminole Sulphur Tishomingo		
Type of Insurance: Medicaid Medicare Private Insurance None		
Type of modifice. Medicald Medicale Frivate insurance None		
Policy Number:	Group Number:	Phone Number:

HOPE

DEDICATION

COMMUNITY