Laurel Hill CENTER

Provider Referral Form

Fax completed form to (541) 984-3124

Please contact us with any questions at (541) 485-6340

PLEASE READ BEFORE COMPLETING THIS REFERRAL FORM FOR LHC SERVICES

- Housing Stability
- Behavior or Safety Issues
- Accessing Community Resources
- Assistance with Basic Needs (cooking, budgeting, medication support, health care access)

If the individual you have assessed **requires two or more contacts a week** (3 or more hours/week) **and care coordination** to address any of the above areas, do not use the form below. **Instead**, complete a referral for Assertive Community Treatment (ACT) and submit to the Exceptional Needs Care Coordinator.

PROVIDER INFORMATION

Name of Person Completing Referral _____ **Date** _____

Type of Referring Organization

☐ Behavioral Health Provider
☐ Hospital
☐ Acute Care or Emergency Department
☐ Primary Care Provider or Medical Home
☐ Coordinated Care Organization
☐ Crisis Center
☐ Substance Use Provider
☐ Peer Support Program

Name of Referring Organization _____

Phone Number of Person Completing Referral _____

Email of Person Completing Referral _____

Your relationship to the individual _____

CLIENT INFORMATION

Client Name _____

Date of Birth *(MM/DD/YY)* _____

Gender Identity _____ **Legal Gender** ☐ F ☐ M

Pronouns *(Ex: she/her, they/them)* _____

Does the individual have a guardian? ☐ No ☐ Yes

Racial Identity

☐ Alaska Native ☐ Black/African American ☐ Other – single race
☐ White/Caucasian ☐ Asian ☐ Two or more races
☐ Native Hawaiian/Pacific Islander ☐ Native American ☐ Unknown/Decline to state

Ethnicity

☐ Mexican, Mexican American, Chicano/a/x/e ☐ Puerto Rican
☐ Other Hispanic, Latino/a/x/e or Spanish origin ☐ Cuban
☐ Not Hispanic, Latino/a/x/e or Spanish origin ☐ Unknown/Decline to state

Is the individual in need of any translation services? ☐ American Sign Language ☐ Spanish ☐ Other: _____

CONTACT INFORMATION

Phone Number of Individual
(use N/A if none) _____

Email Address of Individual
(use N/A if none) _____

Does the individual consent to Laurel Hill Center providing its name when contacted? Email ☐Yes ☐No Phone ☐Yes ☐No ☐ Unsure

Current Housing Status _____

Address of individual
(Use N/A if status is unhoused)

_____ *(Address Line 1)*

_____ *(Address Line 2)*

_____ *(City)* _____ *(State)* _____ *(Zip)*

Insurance Provider

☐ Trillium Community Health Plan Medicaid ☐ PacificSource Medicaid
☐ CHOICE Funding ☐ DMAP (Open Card)
☐ Supported Employment Scholarship Funds (only for employment services)

OHP ID Number _____
Note: OHP # is 8 characters in length.

Does this individual also have Medicare? ☐ No ☐ Yes

Medicare ID Number _____
Note: Medicare ID # is 11 characters in length. SS# may be needed to verify coverage.

AVAILABILITY

What are the best days of the week for our staff to contact the individual?

☐ Monday ☐ Thursday
☐ Tuesday ☐ Friday
☐ Wednesday

What are the best times of the day to contact the individual?

☐ Mornings (8:30AM-12:00PM) ☐ Afternoons (12:00PM-3:00PM) ☐ Early Evenings (3:00PM-5:00PM)

What is the reason for the referral? _____

_____

_____

_____

_____

CLINICAL INFORMATION

Primary Mental Health Diagnosis _____

_____

Secondary Diagnosis(es) _____

_____

Relevant Social Factors _____

_____

Does this individual have current or past criminal justice involvement? ☐ No ☐ Yes ☐ Unknown

CURRENT PSYCHIATRIC TREATMENT & HISTORY

Current symptoms _____

_____

_____

In past 2 weeks? ☐ Suicidal symptoms ☐ Homicidal symptoms ☐ Destruction of property

Does the individual have a current outpatient mental health provider? ☐ No ☐ Yes

What services, if any, will remain with the current provider? _____

_____

_____

Past Psychiatric History and Treatment

☐ Hx of psychiatric hospitalizations ☐ Hx of violence
☐ Hx of suicide attempts ☐ N/A
☐ Other: _____

Which services are you requesting?

☐ Community Based Skills Training	☐ Supported Employment Services
☐ Individual Peer Support Services	☐ Supported Education Services
☐ Case Management	☐ Groups

Are you also requesting medication management? ☐ No ☐ Yes

Has the individual agreed to being referred to Laurel Hill Center? ☐ No ☐ Yes

Is the individual comfortable discussing their symptoms or diagnosis? ☐ No ☐ Yes

If not, please describe the best way to engage the individual about their symptoms and our services. _____

_____

_____

_____

_____

Additional Information or Comments _____

_____

_____

_____

_____