**Referral** for Behavioral Health Services

**This form is current as of 9/3/2019. Please discard any referral forms prior to this date.**

Thank you for helping someone reach our agency! OBHC has an array of behavioral health services to offer, although matching a client with the best available intervention will require a little teamwork together! You have vital information for us about this client, and we hope this form highlights the minimum necessary information to expedite our connection with the client.

# If the client appears to be in acute distress or may be in imminent danger to self or others, please contact Crisis Services at (509) 826-6191 immediately.

**DO NOT USE THIS FORM FOR EMERGENCIES!**

**Here’s your part:**

Please complete this form by typing into the boxes provided (using the TAB key advances to the next box), print it out, and fax it to the Medical Records Department at 509-826-3029 with the records requested (see below). This form is intended to initiate the enrollment process only. Referrals for other types of behavioral health services (i.e., psychiatric medication services, etc.) are located under the appropriate category on this website. Most additional services require enrollment in OBHC first; any questions about eligibility, availability, or enrollment can be answered by calling 509-826-6191.

# Here’s what you can expect:

OBHC will acknowledge receipt of the referral in 7 days. If you have not received confirmation, please call 509-826- 6191 to check on the status of the referral. Although our request for collateral information (i.e., medical records, school records, legal history, etc., depending on your relationship to the client) requires additional effort on your part, we respect your opinion and area of expertise in helping us to understand the client and your specific concerns. Referrals received without supporting documentation will not be processed. And, even though you have taken the time and effort to support this client through the referral, we cannot guarantee that they will actually follow through despite our best efforts.

# Here’s what the client can expect:

Once the referral is received, a staff member will review the client’s insurance benefits to confirm the client’s eligibility and benefit package. This attention to detail facilitates the client’s timely enrollment and helps to avoid implementation of non-covered services and unexpected bills! Assuming that this referral form and collateral records have been completed and received, our enrollment specialists will contact the client with information about where to find us, what to bring with them, and what to expect. They will also be educated that enrollment is on a “first come, first served” basis. Therefore, they will be given the specific times when enrollment is open. Specific appointments may be available for special circumstances; these arrangements can be discussed with our enrollment specialists by calling 509-826-6191.

The next step of the enrollment process occurs when the client meets with a clinician to discuss the reason the client is presenting and what services we offer. Additionally, the clinician begins to gather information about the client’s current behavioral health concerns and expected goals. Not all the questions may appear to relate to the client’s current situation, yet our professionals must gather details from a range of topics to provide the most accurate diagnosis and treatment plan. If the client chooses to proceed, they will meet with an administrative staff member to provide and receive additional information. Although the client’s participation is done for that given day, a therapist is assigned to the client and will begin to review the clinical information that has been gathered in preparation for the next appointment at a later date. The journey has begun!

# If the client appears to be in acute distress or may be in imminent danger to self or others, please contact Crisis Services at (509) 826-6191 immediately.

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## Date: Referring Facility: Primary Care Provider:

Referent Name: Referent Phone #:

|  |  |  |  |
| --- | --- | --- | --- |
| Client Last Name: |  | Client First Name: | Middle Initial: |
| Date of Birth: |  | Social Security #: |  |
| Street Address:Mailing Address: |  | City/State/Zip:City/State/Zip: |  |
| Patient phone #:Best time to contact: | Morning | Patient cell phone #:Afternoon Evening Any | Insurance: |

Type of Service Requested: Mental Health Psychiatric Medication Services

WISe Substance Use Disorder

Who provides consent on behalf of client?

Self Other (identify name & relationship):

If the client has a guardian or Power of Attorney, please bring legal documentation of this.

**Date client notified of referral**

# Please define the circumstances or specific concern(s) generating this referral:

**If the client appears to be in acute distress or may be in imminent danger to self or others, please contact Crisis Services at (509) 826-6191 immediately.**

**PLEASE DO NOT USE THIS FORM FOR EMERGENCIES!**



**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

|  |
| --- |
| **Name:** |
| **Date of Birth:** | **Client ID #:** |

By signing this Consent for Release of Confidential Information, I authorize **Okanogan Behavioral HealthCare (OBHC)**

## and:

|  |  |
| --- | --- |
| Name: |  |
| Institutional affiliation: |  |
| Phone / Fax: |  |

to communicate with and disclose to one another the following information:

***Nature and amount of the information*** to be disclosed, as limited as possible:

The ***purpose*** of the disclosure authorized in this consent is to (purpose of disclosure, as specific as possible):

I understand my behavioral health treatment records are protected under the Federal regulations governing the

Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(specification of the date, event or condition upon which this consent **expires**)

### This consent automatically expires upon the date of discharge from OBHC regardless of the date or event referenced above.

* I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
* I understand I will be provided with a copy of this form upon request.
* I understand that I have a right to receive a list of entities to which my patient-identifying Part 2 information has been disclosed pursuant to a general designation. This request must be made in writing.

|  |  |
| --- | --- |
| Client Signature: |  |
| Date: |  |

|  |  |
| --- | --- |
| Signature of person signing if not client: |  |
| Date: |  |
| Describe authority to sign on behalf of client: |  |

**NOTICE ON PROHIBITION OF REDISCLOSURE OF CONFIDENTIAL INFORMATION**

***This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.***

*Completed by:*

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