***We’re Here To Help!***

The presence of a behavioral health problem is not only a burden for the sufferer but also interferes with collaborative efforts between the individual and their support system. In addition to direct treatment services, Okanogan Behavioral HealthCare provides a range of consultation services to assist and inform collateral providers who work with clients but who may not specialize in or understand behavioral health issues. The preferred outcome as a result of the behavioral health contact determines the type of consultation service to request. The costs for services rendered are listed on the fee schedule located elsewhere on the OBHC website. **Please review and choose one of services below, type the requested information, print out, and fax to *509-826-3029 If acknowledgement of receipt by OBHC is not confirmed in 7 days, please call 826-6191 to check on the status of the 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. DO NOT USE THIS FORM FOR EMERGENCIES!**

**Court-Ordered Behavioral Health Assessment**

The purpose of a Behavioral Health Assessment, which is conducted by a mental health professional, is to assess whether the client meets criteria for a mental illness diagnosis and to identify basic intervention strategies. Since there are over 300 recognized psychiatric disorders and limited time to conduct the evaluation, the referent is encouraged to specify a succinct referral question to help focus the breadth of the evaluation, increasing the likelihood that the written report will provide the desired information. A consultation report will be sent to the referent within one week. A non-compliance letter will be sent if the client does not keep their appointment. ***Please note:*** This evaluation ***does not*** initiate enrollment or treatment services at OBHC, even if such services are recommended by the consultant.

Requirements of Referent:

[ ]  Copy of court order signed by a judge

[ ]  Referral question (see below)

[ ]  Brief description of what precipitated the referral or collateral information (see below)

[ ]  Copy of legal history

Requirements of Client:

[ ]  Fee paid in full prior to scheduled appointment

[ ]  Authorization signed by the client to release a copy of the report to the referent

[ ]  **Court-Ordered Behavioral Health Treatment**

This service is available for offenders who

* have already completed a behavioral health evaluation
* were diagnosed with a treatable psychiatric syndrome
* meet eligibility requirements to enroll for services at OBHC
* are willing to engage in the recommended behavioral health treatment
* provide a copy of the court-order signed by a judge

Monthly status reports are sent to the referent. Details about the client’s clinical issues or progress are not provided unless authorized by the client and specifically requested by the referent. Because treatment effectiveness is highly dependent on a participant’s engagement in the process, any client whose behavior interferes with treatment (i.e., lack of payment, irregular attendance, lack of progress, etc.) will be subject to a utilization review and may be discharged from services. If this is the appropriate outcome, notification and explanation will be provided to the referent.

[ ]  **Anger Management Skills Group**

This is a seven week course facilitated by a mental health professional that defines anger, identifies triggers, and educates participants about alternative interventions/skills. Participants are not required to be enrolled at OBHC, although non-enrollees are required to pay prior to admittance. Payments are non-refundable. All participants must attend at least Session #2 to continue the course, and attendance to all 7 sessions is required to receive a certificate of completion. Make-up sessions and alternative formats are not available. Therefore, participants who miss any session will have to wait until that specific session is offered again in the next course. Participants who are court-ordered to attend must pre-register and provide a copy of the court order.

**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!**

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:       City/State/Zip:

Mailing Address:       City/State/Zip:

Patient phone #:       Patient cell phone #:       Insurance:

Best time to contact: Morning [ ]  Afternoon [ ]  Evening [ ]  Any [ ]

Type of Service Requested: Mental Health [ ]  Psychiatric Consultation (Dr. Janssen) [ ]

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, and 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**)

* 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 have been provided a copy of this form.
* 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.***

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*Completed by: \_\_\_     \_\_\_\_\_\_\_ Consent for Release of Confidential Information v. 4.25.17*