Health. Justice. Hope.

Referral Form

Fax: 541-447-1121

Client Information (Please fill out COMPLETELY)

Client Name: ____ Client DOB: ______________________

Client Address: ____

Client Phone Number: ____

Contact name (if other than client) ___________________________________

Client Insurance / Payer Source: (Please circle one)

OHP Medicare Self-Pay Private Insurance: ________________________

DHS Courts Mosaic

Suggested Program(s): (Please circle all that apply)

Mental Health Substance Use ACT Medication Management

Intellectual / Developmental Disabilities Anger Management Jail Diversion

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Reason for Referral:

What concerns do you have that led you to refer the client to us?

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***Please attach any relevant clinical documentation/records to this form**

Agency Contact Information: (Please fill out COMPLETELY)

Contact Person's Name: ____

Phone Number: _________________________ Fax Number: _________________________

Relationship to Client: ____

Revised 4/5/18 - SC