OBYKE HEALTHCARE SERVICES

REFERRAL FORM

Please complete this form and fax it along with any available history or physical information on the individual. We will arrange an intake interview and determine eligibility for services.

OBYKE CONTACT INFORMATION
3028 Gentilly Blvd. New Orleans, LA 70122
PHONE: 504-948-6080
FAX: 504-948-6089

RECIPIENT PERSONAL INFORMATION

Name: _________________________________ Date: ________________________

DOB: ______ Age: ______ Grade: _______ Gender: _________ SS#: ___________

Medicaid #: _________________ Medicare# (if Applicable): _________________

Parent/Guardian: _____________________________

Address: ____

Phone: _________________________ Alternate: ___________________________

School/Employer: ____

Presenting Issue (s)

____

____

Referral Source: ________________________________

PRE-SCREENING

____ Recipient has prior mental health diagnosis
____ Recipient's diagnosis has affected his/her educational/work and social functioning.
____ Recipient has documented history of severe psychiatric disability expected to persist for at least a year and required intensive mental health services, as indicated by one of the following.

YOUTH	ADULT
Past Psychiatric hospitalization(s)	Past Psychiatric hospitalization for at least six months duration in the last five years (cumulative total)
Past supported residential care for emotional/behavioral disorder	Two or more hospitalizations for mental disorders in the last 12-month period
Past structured day program treatment for emotional/behavioral disorder	Structured residential Care, Other than hospitalization, for a duration of at least six months in the last five years
Documentation indicating that an impairment or pattern of inappropriate behaviors has persisted for at least three months and is expected to persist for at least six months.	Documentation indicating a previous history of severe psychiatric disability of at least six months duration in the past year

Magellan Health Provider
Carf Accreditation