GLOBAL HEALTHCARE SYSTEMS, INC
PRP & OMHC SERVICE REFERRAL

Please fill out the following information for the client you are referring for service and thereafter mail or fax filled form to

Agency Program Director
1045 Taylor Avenue, Suite 104, Baltimore, MD 21286

OR

***Fax to* (410) 296-1687**

Date of Referral _____
Provider Information/Referral Source: _____
Referring Provider Organization _____
Provider Contact Name/Telephone Number: _____
MD ___ PhD _____ LCSW-C _____ LCPC _____ Others _____

Patient/ Client Name _____ **MA#** _____
DOB: _____ **SS#** _____
Address: _____
Name of person/organization that has custody of child: _____
Guardian's Contact Information: _____

Check Services Requested: OMHC__PRP__TBS__ Primary Care Clinic: __SUD/Suboxone Clinic__
Purpose of Referral: _____
_____
_____

If PRP Services needed, state reasons why OMHC services are not sufficient to address the client's treatment
needs_____
_____

Presenting Problem (with detailed description of maladaptive behaviors):
_____
_____
_____

Multi-Axis Assessment:
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Description of Psychiatric History (include previous treatments and hospitalizations):
_____
_____

Is the child currently receiving other Mental Health Services? ___ Yes ___ No
If so, list service and provider name: _____
_____
Referring Clinician /Therapist Name_____
Clinician Signature_____ **Phone#:** _____