5104 North Orange Blossom Trail. Orlando Florida 32810 Suite 220
Phone: 407 394 7181 , **Fax** 407 250 0788
Alternate Phone Number: 689 201 2702, 407 394 4717
Website: https://www.ohollc.org **Email:** optimumhealthoutcomes@outlook.com

Optimum Health Outcomes, LLC
"Client Centric Focus on Total Wellness"

OHO REFERRAL FORM

Date: _____

CLIENT'S INFORMATION BEST CONTACT EMAIL

Client's Name: _____ Sex: ☐ M ☐ F **DOB:**

Age: _____IN DCF CARE_____ School (or) Job: _____ Grade:

Race: _____ Client's Address: _____

City: _____Zip Code:_____ Parent/Guardian: _____

Cell Phone:_____Alternate # _____ Best Time To Call:_____

Name Insurance: _____Medicaid#:_____

Accepted Medicaid Providers *(Sunshine, Humana, Aetna Better Health, Simply,* ***Staywell/CMS****, Coventry, HealthyKids*

ACESS/DCF CASE # IF MEDICAID UNKNOWN

PLEASE check BEHAVIOR SYMPTOMS exhibited by client:

☐ Non-Compliance
☐ Lying
GRIEF ☐
☐ Self-Injury
Homelessness ☐
☐ Stealing
Mood Swings ☐
☐ Depressed Mood
☐ Inappropriate Sexual Behavior

☐ Physical Aggression
☐ Disruptive Behavior
☐ Sleep Disturbance
☐ Eating Disorder
☐ Poor School Grades

Other: . -

☐ Verbal Aggression
☐ Tantrum Behavior
☐ Runaway Behavior
☐ Property Destruction
☐ Substance Abuse

Abuser Sexually ☐
Abuser Physically ☐
Sexually Abused ☐
Physically Abused ☐
Delusional ☐
Homicidal ☐

Indicate SERVICES DESIRED BELOW

☐ Targeted Case Management (Adult)
☐ Intensive Adult Targeted Case Management
☐ Individual Counseling
☐ Famil Counseling
Other Support Services Needed _____

☐ Targeted Case Management (Child) Family Counseling
☐ Tutoring (*Contingent upon availability)
☐ Mentoring (*Contingent upon availability)
☐ Group Counseling

Referral Source:

Name: _____ Referring Person/**Agency:**

Phone_____**Email**_____ _

Re 10/24/2014,7/14/2021

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OHO REFERRAL FORM

ANY OTHER DETAILS FOR REFERRED PERSON AND FAMILY

ANY OTHER FAMILY MEMBERS NEEDING SERVICES? LIST

* NAME
*DOB

* NAME MEDICAID PROVIDER
* MEDICAID NUMBER IF KNOWN
* DCF/FLORIDA FOOD ACCESS NUMBER IF KNOWN