5104 North Orange Blossom Trail. Orlando Florida 32810. Phone: 321 758 7186. Fax 407 250 0788
Email. optimumhealthoutcomes@outlook.com

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

OHO REFERRAL FORM

Date: _____

IF FAMILY ADDITIONAL INFORMATION FOR REFERRAL MUST BE ADDED TO THE FORM

REFERRAL INFORMATION.

Will There Be More than One Person From A Family Included on the Referral: ☐ Yes ☐ No

NUMBER OF FAMILY MEMBERS TO BE INCLUDED IN THE REFERRAL::_____ Do all FAMILY members live in the Same Home: ☐ Yes ☐ :No

FAMILY CONTACT NAME: _____ CLIENT/FAMILY EMAIL Address:_____

CLIENT'S/FAMILY INFORMATION

ALL INFORMATION LISTED DIRECTLY BELOW IS FOR INDIVIDUAL CLIENT / OR REFERRED FAMILY MEMBER #1. ☐

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

Client's Name (OR Name of First REFERRED Family Member): _____

BIRTH GENDER ☐ :Male ☐ :Female DOB :_____ Age: _____ IN DCF CARE: ☐ Race: _____GRADE: _____

School (or) Job: _____ BEST CONTACT PHONE #: _____

BEST TIME TO CONTACT?: _____ ALT CONTACT PHONE #: _____

CLIENT/FAMILY PRIMARY ADDRESS: _____ City:_____Zip Code:_____

NAME OF INSURANCE: _____ MEDICAID NUMBER(CLIENT/FAM #1:_____

IF MEDICAID NUMBER IS UNKNOW LIST DCF CASE NUMBER(dcf-access.dcf.state.fl.us): _____

PLEASE IDENTIFY BEHAVIOR SYMPTOMS exhibited by referral/ family member

Non-Compliance ☐ Physical Aggression ☐ SELF INJURY ☐ LYING ☐	☐Greif ☐HOMELESSNESS ☐ Tantrum BehavioR PROPERTY DESTRUCTION ☐	☐Appetite Changes ☐POOR SCHOOL GRADES ☐RUNAWAY BEHAVIOR	☐HOMICIDAL ☐ SUICIDAL ☐DELUSIONAL/HALLUCINATING ☐DISRUPTIVENESS
Verbal Aggression ☐ Stealing ☐ ☐INAPPROPRIATE SEXUAL BEHAVIOR	☐Anxious/ Anxiety ☐DEPRESSION ☐SLEEP DISTURBANCES	☐EATING DISORDER ☐SUBSTANCE ABUSE OTHER ☐:	ABUSER(SEXUALLY/PHYSICALLY, ETC) ☐ ABUSED(SEXUALLY/PHYSICALLY, ETC) ☐ OTHER ☐

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PLEASE INDICATE SERVICES DESIRED:	
☐Targeted Case Management	☐Family Counseling (VIRTUAL/OFFICE)
☐Intensive Adult Targeted Case Management	☐ Individual Counseling (VIRTUAL/OFFICE)
☐Mentoring (AVAILABILITY*)	☐ Tutoring (AVAILABILITY*)
☐ Individual Counseling (VIRTUAL/OFFICE/SCHOOL)	☐ Group Counseling
Other:	

Referral Source:

Name: _____**Agency:** _____

Phone_____**Email**_____

ADDITIONAL FAMILY MEMBER FOR THE REFERRAL: EACH ADDITIONAL PERSON: NAME, DOB, MEDICAID NUMBER, ADDRESS IF DIFFERENT FROM ABOVE, ADDRESS, LIST CONTACT NUMBER FOR THE REFERRED CLIENT IF DIFFERENT FROM ABOVE, LIST OF SYMPTOMS. LIST AS MUCH INFORMATION AS NEEDED