Ocean State Behavioral
Building Better Behaviors

Referral Form

HBTS/PASS

(Please circle one)

DATE referral received: _____

Primary language: ☐ English ☐ Other: _____
(Please specify language)

DEMOGRAPHIC INFORMATION

Client Name:_____ DOB: _____

SSN:_____ Sex: ☐ M ☐ F

Primary Contact:_____ Relationship to client:_____

Address: _____ Home #: _____

_____ Cell #: _____

Email: _____

Primary Insurance Type: ☐ NHP ☐ UBH ☐ Tufts ☐ Medicaid Other_____

Member ID:_____ Group ID _____

DIAGNOSTIC INFORMATION

Diagnosis (DSM V): _____

Diagnosed by: _____ Approximate Date: _____

PROVIDERS

Primary Care Physician: _____ Phone Number: _____

Relevant Medical information: _____

_____

School Name: _____ Grade: _____

IEP: ☐ Yes ☐ No Supports: ☐ Speech ☐ OT ☐ PT ☐ APE ☐ ESY ☐ Other Accommodations

CHIEF COMPLAINT/PRESENTING ISSUE:_____

_____

Other Services child is receiving at this time: ☐ Yes ☐ No

_____

MALADAPTIVE BEHAVIORS (what do they look like, frequency, intensity, duration, etc.)

☐ Aggression _____

☐ Non-compliance _____

☐ Tantrum _____

☐ Self-Injury _____

☐ Eloping _____

☐ Other _____

☐ Other _____

☐ Other _____

OTHER:

_____

_____

REFERRAL INFORMATION

Referral Name:_____ Phone:_____

Agency/Affiliation:_____

OSB office use only REFERRAL CHECKLIST

☐ Parent/ guardian was informed they need to supply documentation from a medical professional confirming the child's diagnosis

☐ Parent/ guardian has agreed to complete an adaptive assessment and have the document ready and available at the intake appointment.

OSB OFFICE USE ONLY: **Phone Log**

Clinician Assigned: _____ **Coordinator Assigned:** _____

OSB ID: _____ **Intake to be completed on or before:** _____