AR NextStep
Counseling Services

REQUEST FOR OBHS SERVICES

2315 Matthews Ave.
Jonesboro, AR 72401
TEL: 870.277.4357 FAX: 870.572.2892

First Name_______________________ Last _________________________ Gender __________

Date of Birth ___________________________ SSN ____________________________________

Mailing address ____
Street *City* *State* *Zip*

Physical address ____
Street *City* *State* *Zip*

Primary Phone Number ___________________________ Permission to leave a message? Y N

Alternate Phone Number __________________________ Permission to leave a message? Y N

Referred by ____
Name *Relationship to referral*

Reason for Referral ____

____

Emergency Contact:_________________________________ Phone: ________________________

Use additional sheets if necessary

Current and/or Previous Mental Health Services	Y	N
Has the referral been hospitalized for any condition in the past 6 months? ____________________	Y	N
Has a mental health professional ever diagnosed the referral with a pervasive developmental disorder?	Y	N
Has the referral been court ordered for services in past 6 months? If yes, County _______________	Y	N
Has the referral been placed in foster care?	Y	N
Has the referral currently or recently wanted to kill THEMSELFS? *	Y*	N
Has the referral currently or recently wanted to kill SOMEONE? *	Y*	N
Does the referral currently or recently wanted to hurt THEMSELVES or OTHERS? *	Y*	N

*Any referral answering YES to these questions will be **IMMEDIATELY** assessed

UNDER 21 OUTPATIENT

Guardian Name* ____
Name(s) *Relationship to referral*

Father's Name ______________________ Father's Employer ________________________

Father's Work Phone ______________________________ May we leave a message? Y N

Mother's Name _____________________ Mother's Employer _______________________

Mother's Work Phone _____________________________ May we leave a message? Y N

School District*__________________________School Building _____________Grade _____

School Address ____
Street *City* *State* *Zip*

**If School-based services are available and if the child qualifies, would parent/guardian like for the child to be seen at school?* Y N

OVER 21 OUTPATIENT

Employment Status: Disabled Full Time Laid Off Medical Leave Part Time

Retired Self-Employed Social Security Student Unemployed

Marital Status: Divorced Married Other Separated Single Unknown Widowed

PSYCH TESTING

Has the referral ever participated psychological testing? Y N

If Yes, who completed the testing and when? ____

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INSURANCE INFO

Medicaid number ______________________ Medicare number_______________________

Private Ins. Company ________________________ Phone number _____________________

Group number _________________________Policy number ___________________________

Name of Cardholder _________________________________ Cardholder DOB ___________

Relationship of Cardholder to Referral ____

Cardholder's Social Security Number ____

Cardholder's Employer ____