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 _____

_____

PASSE:_____ Care Coord:_____

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? _____

_____

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 _____