Health Services Secure › Internal Referral Process: New Item

Deschutes County Health Services
Internal Referral Form

**Denotes Required Fields*

All referrals should be closed within seven days.
If client needs are urgent, please provide a warm hand-off to the appropriate program.
For Behavioral Health Crisis, please refer to the crisis team.

Client's First Name:	* First Name as it appears on OHP card
Client's Last Name:	 Last Name as it appears on OHP card
Parent or Guardian's First Name:	 Please fill out If client is a minor
Parent or Guardian's Last Name:	 Please fill out If client is a minor
Client's Birth Date:	* MM/DD/YYYY
Pregnancy Due Date:	MM/DD/YYYY If referring to Nurse Home Visiting, OMC, or WIC, please specify due date.
Client on OHP?:	Yes
Gender:	*
Phone(s):	
Address:	 Street, City, State, Zip
Interpreter Needed:	○ Yes ◉ No
Language:	English Fill-in choice is OK
Voice Message OK:	○ Yes ○ No ◉ Not Asked Safety concerns? Please indicate in the Referral Reason section
Text Message OK:	○ Yes ○ No ◉ Not Asked Standard text rates apply
Appointment Status: (Warm Hand-Off)	◉ Not Scheduled ○ Scheduled Have you already helped client schedule the referral appointment?
Appointment Date: (Warm Hand-Off Date)	MM/DD/YYYY **DISABLED - No Appointment Scheduled**
Referred by:	* What Program or Service are you from? If Program or Service is not listed, **cancel this referral** and **contact help desk.**
Referred to:	* **Level 1** - Any DCHS clinical staff person can make this referral. **Level 2** - Only clients already enrolled in Behavioral Health Services can be referred. A Behavioral Health clinician must make the referral. If Program or Service is not listed, **cancel this referral** and **contact help desk**.
Referral Reason and Notes: Please include any information pertinent to this referral, including referral reason, safety concerns and safety of home conditions, client's situation, and etcetera.	

Submit Referral for Processing