OREGON DEPARTMENT OF HUMAN SERVICES
REFERRAL FOR MORRISON OUTPATIENT SERVICES

PLEASE FAX COMPLETED FORM AND CHILD'S
TO INTAKE CALL CENTER AT (503) 872-0659
(Or call Intake Call Center Phone (503) 542-3025)

Client: _______________	DOB: _______________

___Oregon Health Plan # ____________
___ Uninsured (if so, pls include the info below)
Hshld income__________ #of in hshld_____
MCFS requires clients be eligible for OHP

Date of Referral:________________________

Legal Guardian: _________________________ Relationship to client_________ Phone # _____________

Person child lives with: ____________________ Relationship to client__________ Phone # ____________

Client's address: ____

Client's school:____

Parent/caregiver is aware of this referral and agrees to being contacted by Morrison? ___ Yes ___ No
Will family need a Spanish-speaking therapist? ___ Yes ___ No
Will family need other language interpreter services? ___ Yes ___ No If Yes, pls specify? ___________

Referring DHS CMC/CW Name & Phone:_______________________________________EXT#________
Clinic: ___ Gresham ___ N/NE ___ St. Johns ___ Other_______________________
___ New Market ___ Midtown ___ East

Services Requested:____
____
____

Identified Concerns/Observations:____
____
____

Client's Primary Care Physician:____
Significant illness/health information:____
Medications:____

Morrison Site requested:

___ Division Office	___ Irving Office	___ W.Gresham	___ Knott Office
1818 SE Division St	1500 NE Irving, #250	2951 NW Division	11456 NE Knott
Portland, OR 97202	Portland, OR 97232	Gresham, OR 97030	Portland OR 97220
(503) 258-4320	(503) 258-4555	(503) 258-4600	(503) 736-6500

MORRISON CALL CENTER STAFF WILL CONTACT PARENT/GUARDIAN TO SCREEN AND SCHEDULE INTAKE APPOINTMENT