

REFERRAL FOR MORRISON
OUTPATIENT SERVICES

****PLEASE FAX COMPLETED FORM (AND RELEASE OF INFORMATION)**
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 _____
**MCFE 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, which language?** _____

Referring Provider & Phone #: _____ **EXT#** _____

Agency/Program: _____

Release of Information Obtained? ___ Yes (Please fax with this form) ___ No (though patient agreed to be called)

Services Requested: _____

Identified Concerns/Observations: _____

Client's Primary Care Physician: _____

Significant illness/health information: _____

Medications: _____

Morrison Site requested:

____ **Division Office**
1818 SE Division St
Portland, OR 97202
(503) 258-4320

____ **Irving Office**
1500 NE Irving, #250
Portland, OR 97232
(503) 258-4555

____ **W.Gresham**
2951 NW Division
Gresham, OR 97030
(503) 258-4600

____ **Knott Office**
11456 NE Knott
Portland OR 97220
(503) 736-6500

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