

Health Home Referral

First name: _____ Last Name: _____

Legal Authorized Rep: _____ DOB: _____ SS#: _____

Address: _____ Phone: _____

Other contact information: _____

Medicaid #: _____ Medicare #: _____ SSI ____ SSDI ____

Diagnosis - Include both behavioral health and medical

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Reason for referral: _____

Any known treatment providers:

Referred By: _____ Agency: _____ Date: _____

Phone: _____ Email: _____ Fax: _____

Has the member been notified of this referral? Yes No

Please note: this referral may be forwarded to Malissa McEntire, Manager of Integrated Care with the Oklahoma Department of Mental Health and Substance Abuse Services at mmcentire@odmhsas.org, or fax to 405-522-6809. Or you may forward to the Health Home program designated to serve the consumer's respective service area directly.

You can find the list of Health Home Providers by city at <https://www.ok.gov/odmhsas/documents/HH%20DIRECTORY%20by%20city.pdf>