



OASIS: A HOLISTIC NETWORK, LLC

2906 N Heritage Street, Suite B, Kinston, NC 28501-1513

Member Screening and Referral

Member Name: _____

Date of Referral: _____

Discharge Date: _____

Acuity of Need:

Emergent – within 2 hours or immediately upon presentation

Urgent – within 48 hours of presentation or notification

Routine – within 14 calendar days

Medicaid/HC/Insurance#: _____ Date of Birth: _____

Sex: Male Female Unknown Other *If other please explain:* _____

Home Address: _____

County: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Do you have access to Duo? Yes No or Do you have access to Google Meet? Yes No

Parent/Legal Guardian (if applicable): _____

Does the Legal Guardian have access to Legal Documents verifying Guardianship? Yes No

Do you have an Advance Directive? Yes No

Referring Individual/Agency (if self indicate "Self"): _____ Phone: _____

Person Making Referral (if self indicate "Self"): _____ Phone: _____

Presenting Problems/Reason for Referral (should state specifically in quotations what the member/legal guardian needs": _____

Instrumental Activities of Daily Living Needs?

Can you:

- Use the phone, including answering and calling others? Yes No
- Shop for groceries on your own? Yes No
- Do you ever cook using your stove? Yes No
- Plan, heat, and serve your own meals? Yes No
- Manage your medicines? This includes refilling them when needed and taking them correctly. Yes No
- Explain why you are taking certain medications? Yes No
- Take your medication on your own? Yes No
 - If no, who helps you take your medication? _____
- Clean your house or apartment on your own? Yes No
- Get around on your own, either by car, taxi, or public transportation? Yes No



- How do you get to the store or to appointments? _____
- Manage money and pay bills? Yes No
- Do you pay your own bills? Yes No Do you write checks or money orders yourself? Yes No
- Do you go to the bank on your own? Yes No

Screening/Referral Form

Individual Name: _____ Medicaid/HC/Insurance#: _____ Date of Birth: _____

What do you want to work on? What would you like to accomplish?
What strengths do you currently have?
What are the obstacles/barriers to meeting your goals?
What I am like when I am feeling well. Describe what a good day looks like for me and provide examples of how I feel when I have a sense of overall wellness and wellbeing. Describe how I interact, appear, and behave.
Early signs that I am not doing well. Significant event(s) that may create increased stress and trigger the onset of a crisis. Examples include: anniversaries, holidays, noise, change in routine, inability to express medical problems or to get needs met, need medication(s), being isolated, etc. Describe what one may observe when I go into crisis. Include lessons learned from previous crisis events. Examples include: not keeping appointments, isolating myself, communicate loudly/hyper-verbal, etc.
Ways that others can help me...what I can do to help myself. Crisis prevention and early intervention strategies that have been effective. Describe prevention and intervention strategies that have been effective in keeping me out of crisis and/or restrictive facilities. Note any individuals to whom I respond best. Examples include: breathing exercises, journaling, taking a walk, etc.
Ways that others can help me...what I can do to help myself. Strategies for crisis response and stabilization. Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help me to become stable.
What has worked well with me...what has not worked well. Acceptable and unacceptable treatments that have and have not worked in past crises; Specific recommendations for interacting with the person during a crisis. Describe preferred and non-preferred treatment facilities, medications, etc. Describe how crisis staff should interact with me when entering a crisis. For example, I like music, I like to go for a walk, I like to be talked to, peer counseling, I don't like to be talked to, I don't like to be touched, etc.

Natural Supports (i.e. family, friends):

Name & Phone Number	Male or Female	Relationship



Professional Supports (i.e. providers, community supports):

Name	Address	Phone Number:	Service(s) Received:

Existing Physical Health/Medical Diagnosis(es): _____

Existing Mental Illness/Diagnosis(es): _____

Infectious Disease(es): _____

Current Medication(s): _____

Allergy(ies)/Adverse Reactions to Medications or Other Items: _____ None Reported/None Known Allergies

History of any of the following behaviors: Abusive Violent Sexually Inappropriate:

(If so, briefly explain): _____

Do you have any thoughts to harm yourself right now?: Yes No *If so, ask if you can direct the Member to a therapist immediately.* Have you had thoughts to harm yourself in the past? Yes No (If so, briefly explain):

Do you have any thoughts to harm anyone right now?: Yes No *If so, ask if you can direct the Member to a therapist immediately.* Have you had thoughts to harm anyone in the past? Yes No (If so, briefly explain):

Additional Information (include hospitalizations, medical records, psychological assessments, psychiatric evaluations, etc.): _____

Has the individual been unsuccessful with other mental health services? If yes, please list previous services. _____

Are you taking any substances other than your medicine prescribed by a doctor (i.e. illegal substances, alcohol, etc)?

Screening/Referral Form

Individual Name: _____ Medicaid/HC/Insurance#: _____ Date of Birth: _____

**Social Determinants of Health
Health and Safety Screening**

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	<input type="checkbox"/>	<input type="checkbox"/>
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you worried about losing your housing?	<input type="checkbox"/>	<input type="checkbox"/>



5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?	<input type="checkbox"/>	<input type="checkbox"/>
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?	<input type="checkbox"/>	<input type="checkbox"/>
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?	<input type="checkbox"/>	<input type="checkbox"/>
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?	<input type="checkbox"/>	<input type="checkbox"/>
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.	<input type="checkbox"/>	<input type="checkbox"/>
11. Would you like help with any of the needs that you have identified?	<input type="checkbox"/>	<input type="checkbox"/>

*Excerpt from NC DHHS: Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource Needs in North Carolina

Referral Recommendations at the time of Screening (Please check all that apply):

No referral recommended at this time

- Behavioral Health/Comprehensive Clinical Assessment
- B3 Individual Support
- B3 Individual and/or Group Respite
- B3 Community Guide
- Outpatient Therapy
- Psychological Testing
- Residential Services-Level III Group Home
- Residential Services-Assisted Family Living (AFL)
- Other Services *If known, please indicate: _____* or select **Unknown**



Screening/Referral Form

Individual Name: _____ Medicaid/HC/Insurance#: _____ Date of Birth: _____

Does the individual meet the criteria for the services provided by Oasis: A Holistic Network, LLC?

Yes No

If not, please indicate who the individual was referred to: (Agency Name/Community Resource, Contact Person, and Phone Number): _____

If a service(s) are not provided by Oasis: A Holistic Network, LLC, the individual requesting services will be provided with a list of other professional agencies and community programs

List Provided: Verbally Resources Handout Provided

***Insurance Source Verification (contact Source by phone or online): Expiration Date: _____**

Oasis Staff Signature

Date



OASIS: A HOLISTIC NETWORK, LLC

2906 N Herritage Street, Suite B, Kinston, NC 28501-1513

Identification Face Sheet/Emergency Information

Individual Full Name: _____ DOB: _____
(First, Middle, Last) Maiden (if applicable)

Admission Date: _____ Planned Discharge Date: _____ Actual Discharge Date: _____

Race: _____ Gender: _____ Marital Status: _____

IDENTIFYING INFORMATION

Home Address: _____ County: _____

Home Phone: _____ School/Grade/Vocation: _____

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

Legal Guardian Name/Phone: _____

Others in the Home (Names/Relationship to Consumer): _____

Significant Others Involved with Consumer: _____

IN CASE OF AN EMERGENCY

Emergency Contact: _____ Relationship to Consumer: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

Primary Care Office/Preferred Physician's Name: _____

Primary Care Office/Preferred Physician's Address: _____

Primary Care Office/Preferred Physician's Phone: _____

Preferred Hospital: _____

Do you have an Advance Directive? Yes No

Health History, Pertinent Medical Issues & Risk Factors: _____

Known Allergies, Medication Allergies, Adverse Reactions: No Known Allergies Yes: Please indicate any

known allergies or adverse reactions: _____

Medications: _____



Identification Face Sheet/Emergency Information

Individual Name: _____ Medicaid/HC/Insurance#: _____ Date of Birth: _____

MENTAL HEALTH/BEHAVIORAL INFORMATION

Recent Mental Health/Intellectual or Developmental Disability/Substance Abuse Treatment History (last 12 months): _____

Other Active Service Providers (last six months): _____

Court Involvement and/or Pending Charges:

Oasis Staff Signature

Date

