OASIS (Outreach, Assistive Services & Integrated Supports)
REFERRAL FORM

Client Name:		Referral Date:	
DOB:		Name of person referring:	
Address:		Care Facility or AFH:	
Phone:		Has an ROI been signed?	

Eligibility:

Individual is an adult or older adult with medical, physical, intellectual or developmental challenges who is experiencing a mental health condition resulting in the need for behavioral health services, AND at least one of the following circumstances (check all that apply):

- ☐ Is unable to come to the Yamhill County Adult Behavioral Health outpatient clinic due to chronic medical/health condition(s) or physical limitations.
- ☐ Would benefit from an outreach model of services due to ongoing challenges associated with comorbid medical conditions, physical mobility issues, or functional impairment related to health status.
- ☐ Resides in a licensed care setting or receives extensive medical/physical care from providers in home.
- ☐ As a result of chronic medical/physical condition(s) or intellectual/developmental disabilities, needs a higher level of care coordination than is available in general outpatient behavioral health services (i.e., requires coordination with NorthWest Senior & Disability Services, Developmental Disability Service Coordinators, care providers and/or staff in care settings, healthcare professionals, other agencies).

Exclusion Criteria (please DO NOT refer if):

- Individual is unable to participate in or benefit from services due to significant cognitive limitations/impairment (major neurocognitive disorder/dementia, delirium that is the result of an acute medical condition, etc.).
- Individual is receiving hospice or palliative care.
- Individual is diagnosed with an SMI and would be better served by a more specialized or intensive treatment program (i.e., ACT, CSA, etc.) due to high crisis utilization, multiple psychiatric hospitalizations in the past year, or issues that would create a safety risk if services were to be provided in the community.
- Individual is opting not to engage in behavioral health services or does not want to participate in program.
- Desire for community-based services is due to challenges with transportation or other general convenience factors.

Please provide any additional information that will help determine if OASIS is the best fit for this individual as well as details about any relevant special circumstances or needs:

Is client aware this referral has been made? ☐ YES ☐ NO

Please email completed referral form to the OASIS team: oasis@yamhillcounty.gov

For OASIS Team Use Only

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OASIS Screening Outcome:

Client Name: _____
Screening Date: _____

☐ Screened In/Accepted
☐ Client Declines

☐ Screened Out
(if screened out, please provide brief explanation/rationale):
_____
_____

Screener: _____ Date: _____

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