Oregon Change Clinic

REFERRAL FORM

CLIENT INFORMATION

Full Name: _____ D.O.B.: ____ / ____ / ____

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Other: _____

Phone Number: _____

Health Insurance: _____ ID#: _____

Services needed: ☐ Substance Use Disorder ☐ Temporary Housing for IOP clients

☐ TMS ☐ Mental Health

Current Rx medications: _____
(Include dosages, attach additional list if needed) _____

Does this client have any previous convictions for sex offenses, violent crime, or arson?	☐ Yes	☐ No	**If yes, these charges must be discussed with the clinical team prior to housing admit.*
Has this client had any suicidal ideation/attempts in the last 30 days?	☐ Yes	☐ No	**If yes, please supply additional information.*
Does this client identify as BIPOC (black, indigenous, or a person of color)?	☐ Yes	☐ No	
Does this client currently receive mental health treatment?	☐ Yes	☐ No	

REFERRING PROVIDER INFORMATION

Referring Provider Name: _____

Agency: _____

Phone Number: _____

Email: _____

1817 NE 6th Avenue
Portland, OR 97212
(503) 719-7985
(503) 994-5262
Office@OregonChangeClinic.com

Send this document to OCC along with a signed release of confidential information so we can continue to coordinate client care. Please also send any relevant medical or legal records. We will reach out to you and the client with next steps.