OMHC/OP Initial Contact Sheet

Level of Care Requesting (check all that apply): _____ MAT _____ Psychiatric Medication Management

_____ Outpatient Substance Abuse Treatment _____ Outpatient Mental Health Treatment

Full Name: _____ **Preferred/Chosen Name:** _____

DOB: _____ **Social Security #:** _____

Phone #: _____ **May we… Call?** Y / N **Text?** Y / N **Leave a Message?** Y / N

Address: _____

Email: _____ **May we email you?** Y / N

Referral Source: _____

Marital Status: _____ **Sexual Orientation:** _____

Race: _____ **Ethnicity:** _____

Sex (born as): _____ **Gender (identify as):** _____ **Preferred Pronouns:** _____

Drug of Choice and Date of Last Use (if applicable): _____

MAT? If so, what medication and where are you currently enrolled? _____

Medical Issues: _____

_____

Allergies: _____

Mental Health Diagnosis: _____

Current Medications (Name, Dosage & Frequency): _____

_____

_____

Motivation for Treatment: _____

_____

Insurance Type (e.g., Medicare, Medicaid, Private Insurance): _____

Health insurance Provider: _____ **Policy ID / MA #:** _____

Do you have a valid driver's license, identification card or a photo ID? _____

Do you have a copy of your insurance card? _____

***** IF THE INDIVIDUAL HAS OUT OF STATE MEDICAID, THE INSURANCE MUST BE TRANSFERRED TO MARYLAND PRIOR TO ARRIVAL. *****

Name of Individual Completing Initial Contact Sheet: _____

Signature of Person Completing Initial Contact Sheet: _____

Date of Initial Contact Sheet Completion: _____