OUTLETS FOR HOPE, INC.
Outlets for Hope, Inc.
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Referral for Outpatient Services Form

____
Date Referral Agency Name Staff Contact Address Telephone Number

Full Name: ____ ____________
Last *First* *M.I* Maiden Name/A.K.A

Address: ____
Street address

____
City *State* *ZIP Code*

Date of Birth:______________________________ Sex: Male ☐ Female ☐ Other ☐ __________

Phone: ___________________________ Email_________________________________

Social Security No. ______________________

Anticipated first Outpatient appointment date(s) _________________ _________________

Insurance Plan & Member ID#: ____

Is patient member of any Beacon Health Options plan? YES ☐ NO ☐ Does patient have MBHP Insurance? YES ☐ NO ☐

Does patient's insurance plan part of the following network(s): BMCHP BMC HealthNet Plan, BMCHP SCO BMC HealthNet SCO, Fallon Health?

YES ☐ NO ☐

____

Accepted Insurances	Please Check Off Insurance(s) Patient Has
Allways Health Partner / MGBHP	
Beacon Health Options | Carelon	
Cigna and Evernorth	
BMC HealthNet	
Fallon Health	
UnitedHealthcare UHC | UBH	
Tufts	
Harvard Pilgrim	
MassHealth (CCC, Steward Health Choice, Primary Care Clinical, MassHealth Network)	
Medicare	
Aetna	

Blue Cross Blue Shield of Massachusetts	
Other (Please Write in Insurance Name)	

Has precertification/prior-authorization been obtained? YES ☐ NO ☐ Approved ☐ denied ☐ unknown ☐

Circumstances leading to referral for Outpatient Treatment/Counseling:

Is the patient a member of any of the following groups? Check any that apply (If none leave blank):

Veteran ☐	Drug Court ☐
Native American ☐	Under age 19 ☐
Hispanic ☐	Current legal problems ☐
Pregnant Woman ☐ Due date:	

Primary Language:

English ☐	ASL ☐
Spanish ☐	Other ☐

Current Use report

Substance	Amount	Frequency of use	Last date of use
☐ Alcohol			
☐ Cocaine			
☐ Marijuana			
☐ Heroin			
☐ Other:			

Assigned ICD-9-CM diagnosis codes – Please check all that apply:

Substance	*Abuse*	*Dependence*	*Substance*	*Abuse*	*Dependence*
☐ Alcohol	☐ 305.00	☐ 303.90	☐ Amphetamine	☐ 305.70	☐ 304.40
☐ Cocaine	☐ 305.60	☐ 304.20	☐ Sedative	☐ 305.40	☐ 304.10
☐ Marijuana	☐ 305.20	☐ 304.30	☐ Poly-Drug	☐ 305.90	☐ 304.80
☐ Heroin	☐ 305.50	☐ 304.00	☐ Nicotine		☐ 305.10
☐ Other:					

Comments/Other Diagnostic Impressions/Referral Recommendations:
Reason For admission as stated by patient:

What Services and/or Psychotherapy Counseling Module Do you recommend/Anticipate for patient?

DONOT SUBMIT REFERRAL FORM WITHOUT THIS SECTION. Please check as many boxes below that may apply:

Code	Description	Modifier - Fee - Non-Facility						
		U7	U6	SA	HO	HP	AJ	AH
90791	Psychiatric Diagnostic Evaluation Visit							
90792	Psychiatric Diagnostic Evaluation with Medical Services Visit							
90832	Psychotherapy, 30 minutes with Patient and/or Family Member							
90833	Psychotherapy, 30 minutes with Patient and/or Family Member when Performed with an Evaluation and Management service.							
90834	Psychotherapy, 45 minutes with Patient and/or Family Member							
90836	Psychotherapy, 45 minutes with Patient and/or Family Member when Performed with an Evaluation and Management service.							
90837	Psychotherapy, 60 minutes with Patient and/or Family Member							
90839	Psychotherapy for Crisis, first 60 Min							
90840	Psychotherapy for Crisis, each additional 30 Min							
90846	Family Psychotherapy (without the patient) 45-60 Min							
90847	Family/Couple Therapy 60 Minutes							
90853	Group Therapy 60 Minutes							
90882	Case Consultation 15 Minutes							
90887	Family Consultation 15 Minutes							
96112	Developmental Testing, 60 Min							
96116	Neurobehavioral Status Exam, 60 Min							
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional 1 hour							
96130	Psych Evaluation initial 60 Min							
96131	Psych Evaluation add'tl 60 Min							
96132	Neuropsych Evaluation initial 60 Min							
96133	Neuropsych Evaluation add'tl 60 Min							
96136	Psych or Neuropsych Testing & Scoring initial 30 Min							
96137	Psych or Neuropsych Testing & Scoring add'tl 30 Min							
96138	Testing Administration and Scoring by technician, first 30 minutes							
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure) 60 Min							
96146	Psych or Neuropsych Test Administration, with single automated, standardized instrument via electronic platform, automated result							
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. 15-29 minutes of total time is spent on the date of the encounter.							
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. 30-44 minutes of total time is spent on the date of the encounter.							
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. 45-59 minutes of total time is spent on the date of the encounter.							
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or							

Previous Treatment for Alcoholism/Substance Abuse

Type of Treatment (Please Check)			Name of Facility:	Dates of Treatment: From: To:	Completed
Inpatient Residential	Outpatient	Detox			☐ Yes ☐ No
☐	☐	☐			☐ Yes ☐ No
☐	☐	☐			☐ Yes ☐ No
☐	☐	☐			☐ Yes ☐ No
☐	☐	☐			☐ Yes ☐ No

Current/Previous Psychiatric History

Current Psychiatric concerns:
Has this person ever attempted Suicide? ☐Yes ☐No
If yes where they under the influence of any substance? ☐Yes ☐No
Has this person ever experienced homicidal behavior? ☐Yes ☐No
If yes where they under the influence of any substance? ☐Yes ☐No
Has this person ever experienced any psychotic symptoms (hallucinations, paranoia, thought disturbances)? ☐Yes ☐No
If yes where they under the influence of any substance? ☐Yes ☐No
Has this person ever had Mental Hygiene Arrest? ☐Yes ☐No
If yes where they under the influence of any substance? ☐Yes ☐No
Has this person ever been admitted to the psychiatric ER/Hospital locked unit in the last 3 months? ☐Yes ☐No
If yes where they under the influence of any substance? ☐Yes ☐No
If the answer for any of the above is yes, please elaborate on a separate piece of paper and include medical records from facilities (If recent). ***

Previous Psychiatric/Addiction Treatment/Including Childhood

Diagnoses & Conditions	Name of Facility	Dates

Current Medical History

Current Medical History
Current Medical History (Medication name, Dosage, frequency and Indication):
Past medication history (If available):
Any Known Drug Allergies? ☐*Yes* ☐*No* *If yes, please specify:*
Active Medical Problems:
Current Medical Provider (PCP) Name, Affiliated Institution/Facility Name, Address & Contact Phone Number:
Does Patient have any physical limitations: *Yes* ☐ *No* ☐ *If yes describe:*
Last PPD: *Results:* *Any Tx:*
History of COVID-19? *Is patient fully vaccinated? Yes* ☐ *No* ☐ *Other*_______________
Is there a history of seizures (including during withdrawal)? ☐ *Yes* ☐ *No* *If yes describe:*

Current/Previous Legal Issues

Current/Previous Legal Issues
Is patient on Parole? ☐Yes ☐No
Is patient on probation? ☐Yes ☐No
*** If yes to either above please include evaluation document and Parole officer's contact details ***
What County of jurisdiction?
Parole/probation/Drug Court Case Manager/workers name and telephone number below:

*** If patient is incarcerated currently, please include Correctional Medical Services Records (CMS), including medications and dosages received while incarcerated. ***
Does patient have a Sexual Offender Status or current charges? ☐Yes ☐No
If so, what level Sex Offender?

Name & Signature of referring staff: ________________________ Date: ____________

Contact Email: ________________________ Direct Line/Cell phone: ____________