AOS HEALING CENTER

INTEGRATED BEHAVIORAL HEALTH • PROVIDER REFERRAL FORM

Complete this form and submit through an approved secure channel. Please do not email protected health information to an unverified address.

1 REFERRING PROVIDER / ORGANIZATION

Organization / practice: _____

Referring provider and credentials: _____

Phone: _____

Secure fax / secure contact: _____

Referral date: _____

2 CLIENT INFORMATION

Client legal name: _____

Date of birth: _____ Preferred name: _____

Phone / safe contact method: _____

Parent/guardian (if minor) and relationship: _____

Insurance / payer (optional): _____ Member ID (secure submission only): _____

Client informed of referral? ☐ Yes ☐ No Permission to contact client? ☐ Yes ☐ No ☐ To confirm

3 PROGRAM(S) REQUESTED — SELECT ALL THAT APPLY

☐ AOS Restore — Mood, Anxiety & Trauma Recovery. Individual psychotherapy and structured therapeutic groups to support symptom reduction, coping, and daily functioning.

☐ AOS WholeLife — Behavioral & Physical Health Integration. Mental health treatment with health-behavior education, coordination with medical providers, and support for related social needs.

☐ AOS Renew — Co-occurring Mental Health & Substance Use Recovery. Integrated outpatient psychotherapy, recovery skills, and coordination with addiction-treatment partners.

☐ AOS Navigate — Complex Needs & Care Coordination. Enhanced outpatient coordination and treatment support for clients facing persistent mental health challenges and barriers to engagement; not ACT or crisis care.

☐ AOS Thrive Families — Youth & Family Resilience. Age-appropriate counseling, caregiver/family support, and skills-based services for youth and families.

☐ AOS Living Well — Community Prevention & Wellness. Optional wellness education, mindfulness, movement, and workshops; not a substitute for clinical treatment.

☐ Unsure / request AOS assessment and program recommendation

4 REASON FOR REFERRAL / CLINICAL RATIONALE

Presenting concerns (select all that apply):

☐ Depression ☐ Anxiety ☐ Trauma ☐ Stress/adjustment ☐ Substance use ☐ Chronic illness/health behavior
☐ Social isolation ☐ Family/youth concerns ☐ Care coordination barriers ☐ Other: _____

Why are the selected program(s) recommended? Include relevant symptoms, functional impact, client goals, and desired services:

_____

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_____

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_____

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Current diagnosis(es), if known (optional): _____

Current services / providers and coordination needs: _____

5 URGENCY, SAFETY & ACCESS

Referral priority: ☐ Routine ☐ Time-sensitive (explain) _____

Known current safety concerns or relevant accommodations (do not use this form for emergency response):

_____

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_____

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Preferred delivery: ☐ In person ☐ Telehealth ☐ Either Best contact time: _____

Barriers / supports needed: ☐ Transportation ☐ Scheduling ☐ Language/accessibility ☐ Financial ☐ Other: _____

6 ATTACHMENTS & AUTHORIZATION

☐ Relevant assessment/clinical summary ☐ Medication list (if relevant) ☐ Other: _____

☐ Applicable authorization to disclose information attached / verified, when required.

Referrer signature / credentials: _____ Date: _____

AOS will review referrals for clinical fit, service availability, eligibility, and coverage. Program placement is determined collaboratively following assessment; referral does not guarantee enrollment. For immediate danger, call 911; for mental health crisis support, call/text 988.