



OUTPATIENT BIOPSYCHOSOCIAL INTERVENTION (OBI) SERVICES REFERRAL FORM

NAME: _____ LOCAL CASE NUMBER: _____

1. Is the person enrolled in a Waiver Program (HCS, TxHmL, CLASS, DBMD, SPW)? ☐ YES ☐ NO

Persons meeting diagnostic criteria who are enrolled in a waiver program **may** be considered based on acuity of need and service enrollment capacity.

2. Does the person have a diagnosis of an Intellectual Developmental Disability (IDD) or Related Condition, identified on the Approved Diagnostic Codes for Persons with Related Conditions?

☐ YES ☐ NO

List diagnosis: _____ Date of DID: _____ If "YES", skip to #4

3. Does the person have education or medical records that would show an I/DD diagnosis or other Related Condition?

☐ YES ☐ NO

List diagnosis: _____



If you answered "NO" to questions #2 and #3, the person is not eligible for OBI services.

4. Does the person have a diagnosis of a mental health condition or substance use disorder?

☐ YES ☐ NO

List condition: _____

5. Does the person have symptoms that may be associated with a mental health condition or substance use disorder that has not yet been identified?

☐ YES ☐ NO

If Yes, briefly describe those symptoms below:



If you answered "NO" to questions #4 and #5, the person is not eligible for OBI services.

6. Would this person be able to participate in and benefit from adapted skills training to improve their behavioral health?

☐ YES ☐ NO

If Yes, briefly describe the adapted skills the person would like to improve:



If you answered "NO" to question #6, a referral to OBI services is **not** recommended.

Name of Referring Entity: _____ Date of Referral: _____

Relationship to Referred Person: _____

Referred person and/or primary correspondent Phone: _____

Referred person and/or primary correspondent Email: _____

EMAIL REFERRAL TO OBI@texanacenter.com