Behavioral Health Services Referral Form

Date of Referral: _____
Preferred Appointment Type: ☐ In-Person ☐ Telehealth ☐ Either

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Referral Source (Provider Information)

- **Referring Provider/Agency Name:** _____
- **Contact Person:** _____
- **Phone:** _____
- **Fax:** _____
- **Email:** _____
- **Address:** _____
- **Is this referral urgent?** ☐ Yes ☐ No
- If yes, please explain:
  _____

Client Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** ☐ Male ☐ Female ☐ Non-binary ☐ Other: _____
- **Phone Number:** _____
- **Alternate Phone:** _____

- **Email: _____**
- **Preferred Language: _____**
- **Address: _____**

Parent/Guardian (if applicable): _____
Relationship to Client: _____
Phone: _____

Insurance Information

- **Insurance Provider: _____**
- **Member ID: _____**
- **Group #: _____**
- **Policyholder Name (if different): _____**
- **Insurance Type:** ☐ Medicaid ☐ Medicare ☐ Private ☐ Uninsured

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Reason for Referral (Check all that apply)

☐ Diagnostic Evaluation
☐ Individual Therapy
☐ Family Therapy
☐ Group Therapy
☐ Substance Use Evaluation/Treatment
☐ Psychiatric Evaluation
☐ Medication Management
☐ Case Management
☐ Crisis Services
☐ Other (specify): _____

Presenting Issues (brief description):

Relevant History/Additional Notes:

Risk Factors (Check any known concerns)

☐ Suicidal Ideation
☐ Self-Harm
☐ Homicidal Ideation
☐ Aggression/Violence
☐ Substance Use
☐ Trauma/PTSD
☐ Psychosis
☐ Other (explain): _____

Supporting Documentation Attached (if available)

☐ Recent Evaluation/Assessment
☐ Treatment Plan
☐ Progress Notes
☐ Discharge Summary
☐ Medication List
☐ Other: _____

Client Consent

I authorize the release of the information contained in this referral to the receiving behavioral health provider for the purpose of coordinating care and services.

Client/Guardian Signature: _____
Date: _____