CLIENT REFERRAL FORM

SECTION 1: REFERRING PARTY

Your name: _____

Organization: _____

Your role: _____

Phone: _____ Fax: _____

Email: _____

Best way to reach you: □ Phone □ Email □ Fax

SECTION 2: CLIENT INFORMATION

Full name: _____

Date of birth: _____ Age: _____

Phone: _____

Address: _____

Preferred language: _____

If the client is a minor, parent/guardian name and phone:

_____

SECTION 3: INSURANCE

Plan name: _____

Member ID: _____

□ Mercy Care □ Banner University Family Care or ALTCS □ Arizona Complete Health

□ Health Choice □ AHCCCS □ Medicare Part B □ Blue Cross Blue Shield

□ Aetna □ Other: _____

SECTION 4: SERVICES REQUESTED

□ Individual therapy □ Family or couples counseling

□ Psychiatric medication management (ages 8 and up)

□ Direct Support / BHT services □ Case management

□ Comprehensive intake and clinical assessment

□ DUI screening, education, or treatment

Appointment preference: □ In office □ By video □ Either

CLIENT REFERRAL FORM (continued)

SECTION 5: REASON FOR REFERRAL

_____

_____

_____

_____

_____

_____

_____

Is this urgent? □ Yes □ No

If yes, briefly explain: _____

_____

SECTION 6: SUPPORTING DOCUMENTS ATTACHED

□ Prior assessment or evaluation □ Court order or probation documentation

□ Discharge summary □ Current medication list

□ Release of information □ None